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| **Please return completed form to:**  The Oxon Link Team Raglan House  23 Between Towns Road Oxford OX4 3LX  Oxon Link Team [oxonlinkteam@oxfordhealth.nhs.uk](mailto:oxonlinkteam@oxfordhealth.nhs.uk)  Telephone number 01865 903653 |  |
| **Oxon Link Team Referral Form** | |

Please complete as fully as possible by typing into the white spaces

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| **Office use only** | |
| Referral received |  |
| Consultation / Initial Assessment date |  |
| Case ID |  |

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| **Date of Referral** |  |

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| **Client information** | |
| Name |  |
| Date of Birth |  |
| Age at referral |  |
| Gender |  |
| Gender at birth |  |
| Ethnicity |  |
| Religion |  |
| Sexual Orientation |  |
| Pregnant / Maternity |  |
| Home address |  |
| Telephone |  |
| Address at time of referral  (if different) |  |
| Telephone |  |

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| **Next of kin / carer** | | | | | |
| Name |  | | | | |
| Address |  | | | | |
| Telephone |  | | | | |
| Aware of the referral? | | Yes |  | No |  |

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| **GP** | | | | | |
| Name |  | | | | |
| Address |  | | | | |
| Telephone |  | | | | |
| Aware of the referral? | | Yes |  | No |  |

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| **Referrer’s information / Source of Referral** | |
| Name |  |
| Job title |  |
| Address |  |
| Telephone |  |
| Email |  |

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| **Other professionals involved** | |
| Please give names, roles, telephone and email |  |

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| **Who is the lead / co-ordinating professional?** |  |

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| **Previous CAMHS (not Oxon Link) contact?** | Yes |  | No |  | Unknown |  |
| **Has the CYP been previously known to this service?** |  |  |  |  |  |  |

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| **Other agencies involved at time of referral** | |
| CAMHS |  |
| Education |  |
| Social Care |  |
| Police |  |
| YOS |  |
| GP |  |
| Third Sector |  |
| Other |  |
| None |  |

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| **Living arrangements at time of referral** | | | | | | |
| Birth family |  | Criminal justice setting: | | Mental health setting: | | |
| Adoptive family |  | YOI |  | Open unit | |  |
| Other family |  | STC |  | PICU | |  |
| Foster care |  | SCH |  | Low secure | |  |
| Residential care |  |  | | Medium secure | |  |
| Secure care (welfare) |  |  | | |
| Secure care (CJS) |  | Other (please state) | | |  | |
| Residential school |  |
| Semi-Independent living |  |  | | | | |
| Independent living |  |

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| **Social Care status** | | | **Education status** | | |
| LAC – s.20 | |  | Mainstream | |  |
| LAC – s.31 | |  | Mainstream with SEN | |  |
| Leaving care | |  | Special Schooling | |  |
| Child in Need | |  | PRU | |  |
| Team Around the Child | |  | Home Tuition | |  |
| Subject to CP plan | |  | Hospital School | |  |
| Secure Accommodation Order - s.25 | |  | Further Education | |  |
| Allocated Social Worker | |  | CFE | |  |
| No Social Care Plan | |  | Vocational Training | |  |
| Other (please state) |  | | NEET | |  |
|  | | | EHC Plan | |  |
| SEN | |  |
| Left School (Employed) | |  |
| Other (please state) |  | |

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| **Criminal Justice status** | | | | |
| On Bail | |  | Sentenced – Community Order |  |
| Recent Police Contact | |  | Sentenced – Custodial |  |
| On Remand | |  | Not Applicable |  |
| Pre-Court Order | |  |  | |
| Other (please state) |  | | | |

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| **Reason for Referral**  **Please include specific incidents of concern include dates** |
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| **Referral Accepted / Rejection Reason**  **Please include specific incidents of concern include dates** |
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| **Referrer’s anticipated outcome** |
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| **Consent and Information Sharing: -**  Please note, by submitting this referral, you are confirming that you have followed your local consent policies. This includes gaining the relevant consent for referring to our service, and the sharing of appropriate information across agencies involved.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Consent obtained for referral? | Yes |  | No |  | | If no, is there a good reason why the referral should be accepted without consent (eg particular safeguarding/ imminent risk concerns) | Yes |  | No |  | |
| **Please detail any concerns:**   |  |  |  | | --- | --- | --- | | **Young Person’s Name:** | **Signed:** | **Date:** | | **Parent/Carer’s Name:** | **Signed:** | **Date:** | | **Practitioner’s Name: M. Swiatkowska** | **Signed:** | **Date:** | | **Has this form been copied to the young person?** | | | | **Has this form been copied to the parent(s) / carers?** | | | |

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| OFFICE ONLY: Info checked at consultation ¨ |