TRUST LOGO HERE	Referral Date	
	Date Received	
	HCN	

BHSCT ADHD Referral Form

Please complete the electronic referral form and email to communitypaediatrics2@belfasttrust.hscni.net along with all relevant reports and completed questionnaires.

Referrals to the ADHD assessment clinic will only be considered for children aged 6yrs to 11yrs (Primary 7) completed and signed by a health care professional and submitted with a completed school referral form

Referrals for an ADHD assessment will not be considered unless the school information +/- Parent questionnaires are completed and returned alongside this form

Referrer Details			
Name		**Job Title**	
Address		**Email Address**	
		Telephone Number	
Child/Young Persons Details			
Name		**Male/Female/ Prefer not to say**	
Other/previous names		**Date of Birth**	
Home Address		**HCN**	
Postcode		**Ethnicity**	
GP Name		**Name of School**	
Address		**Address**	
Is an interpreter required for child/young person?	Yes ☐ No ☐	**Is an interpreter required for parent/carer?**	Yes ☐ No ☐
Language(s) spoken *(including BSL)*		**Language(s) spoken *(including BSL)***	
Is the child/young person on the Child Protection Register?	Yes ☐ No ☐	**Is the child/young person a Looked After Child?** **Does Trust share care?**	Yes ☐ No ☐ Yes ☐ No ☐

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Name of Social Worker: **Description of previous/current Social Work involvement:**			
Parent/Carers/Guardian's Details			
Name		**Name**	
Relationship to child/young person		**Relationship to child/young person**	
Parental Responsibility	Yes ☐ No ☐	**Personal Responsibility**	Yes ☐ No ☐
Address (if different from Child)		**Address** (if different from Child)	
Postcode		**Postcode**	
Telephone:		**Telephone:**	
Email		**Email**	
Ethnicity		**Ethnicity**	

Previous Interventions/Strategies: e.g. Therapy, Medical, Psychology, Step 2 CAMHS, Step 3 CAMHS, Social Services, Primary Care, Health Visitor, Step1 / 2 Behaviour support / Behavioural Intervention Family Support, Community and Voluntary Support (Max 500 words)

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Services Involved – Please obtain consent from the parent/carer and/or young person (if appropriate) for sharing of information with the other agencies involved.		
Services involved (Past or Present)	**Involved with child/ young person**	**Name of professional and contact number and email address (if known)**
Community Paediatrician		
Occupational Therapists		
Physiotherapists		
Speech & Language Therapists		
Health Visitor/School Nurse		
RISE NI		
Social Work		
Educational Psychology		
CAMHS		
School SENCO		
Juvenile Justice		
Other		

Reasons for Referral
Primary reason for referral: (the triage panel will take this in to consideration when allocating to a pathway) (Max 500 words)
Summary of Presenting Problem: (Please describe in detail the nature and extent of the presenting problems including onset, severity, duration and impact on the child/young person and family functioning) (Max 500 words) Have you identified any risk to this YP or others? Yes/No please specify: Details of any safety planning you have carried out….
Family Structure/Genogram: (Including medical /developmental conditions and relevant family information)
Parent/Carer Concerns: (Max 500 words)
Young Person's Concerns: (were appropriate) (Max 500 words)

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Medical History: (Relevant medication history/medical conditions, disability or confirmed diagnosis including birth history. Please include any previous illnesses/injuries and feeding issues) (Max 500 words)

DEVELOPMENTAL SKILLS

	Concerned *Y/N*	**Brief Description of Concerns**
Gross Motor skills	Tick box	
Fine Motor Skills		
Speech, Language and Communication Skills		
Play Skills		
Sensory Skills		
Social Interaction Skills		
Attention and Listening Skills		
Behavioural Development		

OTHER RELEVANT INFORMATION

Mental Health/Trauma History/Adverse Childhood Experiences- Parental/ Family / Carer:
e.g. any history of serious upsets/accidents/losses /separations/deaths/traumas/domestic abuse.
Past or current mental health services/medications, substance misuse/addictions, child protection concerns (Max 500 words)

Mental Health/Trauma History – Child/Young Person:
Any history of self-harm/self-injury including details, history of threats or actual harm to others (Max 500 words)

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Any history of drug or alcohol misuse? – Child/Young Person: If yes give details (Max 500 words)
Is the child/young person a carer? If yes give details (Max 500 words)
Educational Concerns: (Include evidence/Examples, e.g. Impact on child's learning and child/young person education, Stage of Code of Practice and any education/learning plan as appropriate) (Max 500 words)
Other Relevant Information to Support the Referral: (Max 500 words)

Referral Discussion Points with Person with Parental Responsibility and/or Child/Young Person				
Have you discussed this referral with the child/young person?	**Yes**		**No**	
Has the child/young person consented to assessment/treatment?	**Yes**		**No**	
Consent received for referral/sharing of details to other services? Eg: Family Support Hub, Emotional health and wellbeing team,	**Yes**		**No**	
Have you referred the child/young person to any other services/clinics?	**Yes**		**No**	
If yes, please specify: (Max 500 words)				
Referral Address : Please email completed referral form to communitypaediatrics2@belfasttrust.hscni.net **Please ensure a parental/guardian email address is included for further correspondence (to send questionnaires) regarding this child/young person				