

Child Psychiatry Consultancy Ltd

Specialist Child & Adolescent Assessment | ADHD | Autism | Mental Health

Submit to: referrals@childpsychiatry.uk | Tel: 0207 952 1818 | www.childpsychiatry.uk | * Required

SECTION 1 — REFERRER DETAILS

GP / Clinician name *

Role / title *

e.g. GP, Paediatrician, CAMHS

GP practice / organisation name *

Practice address *

Telephone *

Email address *

Date of referral *

Practice ODS code

SECTION 2 — PATIENT DETAILS

Patient first name *

Patient surname *

Date of birth *

Age *

NHS number *

Gender

Patient address and postcode *

Parent / carer name *

Relationship to patient *

Parent / carer telephone *

Parent / carer email *

Primary language spoken at home *

English
 If other language, please specify

Other — please specify below

Additional needs requiring reasonable adjustments *

Yes — please provide details below
 If yes, please describe adjustments needed

No

Not known

SECTION 3 — REASON FOR REFERRAL

Service requested — tick all that apply *

- | | |
|---|---|
| <input type="checkbox"/> ADHD Assessment | <input type="checkbox"/> Autism Spectrum Condition Assessment |
| <input type="checkbox"/> Combined ADHD and Autism Assessment | <input type="checkbox"/> Child Psychiatric Consultation |
| <input type="checkbox"/> Medication review / second opinion
if other, please specify | <input type="checkbox"/> Other — please specify below |

Primary reason for referral — describe your main concerns *

What has prompted this referral? What are the key difficulties you are observing?

How long have these concerns been present *

e.g. 'Since starting school', 'Past 2 years', 'From early childhood'

Settings where difficulties are most evident *

- | | | |
|---|--|--|
| <input type="checkbox"/> Home | <input type="checkbox"/> School | <input type="checkbox"/> Social situations |
| <input type="checkbox"/> All settings
Please specify if needed | <input type="checkbox"/> Primarily one setting — specify below | |

SECTION 4 — RELEVANT HISTORY

Relevant developmental history *

Include: pregnancy and birth history, early milestones, language development, early concerns, toilet training, sleep

Educational history and current school placement *

Include: SEN support, EHCP, school concerns, exclusions, changes of school, teacher observations

Relevant medical and psychiatric history *

Previous assessments and reports

List any previous ADHD, autism, educational psychology, or CAMHS assessments — include date, provider, and outcome

SECTION 5 — CURRENT MEDICATIONS

Is the patient currently taking any medications *

- No current medications
Medication details — complete if on medication
 Yes — details below

Medication name	Dose	Frequency	Prescriber	Indication

Known allergies or adverse drug reactions

SECTION 6 — SAFEGUARDING

Child Psychiatry Consultancy Ltd takes safeguarding seriously. Please complete this section fully. If there are active safeguarding concerns, please contact us directly before submitting this form.

Current or recent safeguarding concerns *

- No current safeguarding concerns
 Yes — details below

Previous concerns now resolved — details below
If yes, please provide details

Include whether Children's Social Care are involved, any Child Protection Plan, or relevant context

Parental responsibility considerations *

- Single parent / carer
 Parents separated / divorced

Parental responsibility restrictions — see below
If yes, please provide details
 No — standard

SECTION 7 — ADDITIONAL INFORMATION

Any other relevant information you wish to share

Anything else that would help us understand this child's needs and provide the best possible service

Do you have any previous reports or assessments to share *

Yes — I am attaching previous reports / letters No

If yes, please attach documents to your email or post with this form.

Please clearly label each attachment with the patient's name and date of birth.

SECTION 8 — CONSENT AND DECLARATION

DATA PROTECTION NOTICE: Child Psychiatry Consultancy Ltd is the data controller for information in this form.

We process referral data under UK GDPR Article 9(2)(h) — provision of health care.

Information is stored securely in Carebit (our clinical records system).

Full Privacy Policy: www.childpsychiatry.uk/privacy-policy

Data Protection Lead: Dr Athina Zakynthinaki — info@childpsychiatry.uk

I confirm I have appropriate consent from the parent / carer (and young person where applicable) to make this referral and share this information with

I confirm the information provided in this form is accurate to the best of my knowledge *

Referring clinician name (print) *

Signature *

Date *

GMC / professional registration number *

Submit completed form to referrals@childpsychiatry.uk

Or post to: Child Psychiatry Consultancy Ltd, 320 City Road, London, EC1V 2NZ

Telephone: 0207 952 1818 | www.childpsychiatry.uk