**Transition Practitioner Referral Form**

Hammersmith and Fulham Mencap

65 Aspenlea Road

W6 8LH

Tel: 020 8748 5168

**Please complete this form and return it to Kathleen Rao**

kathleen.rao@hfmencap.org

**Date of Referral:**

**Young Person and Family Details:**

|  |
| --- |
| **Young Person** |
| **Name** |  |
| **DOB** |  |
| **Address** |  |
| **Postcode**  |  |
| **Email** |  |
| **Gender** |  |

|  |
| --- |
| **Parent/Carer (whom young person lives with)** |
| **Name** |  |
| **Relationship to child** |  |
| **Contact Telephone** |  |
| **Email** |  |
| **Address*****(If different to child)*** |  |
| **Postcode *(If different to child)*** |  |

|  |  |
| --- | --- |
| **GP Name** |  |
| **GP Address & Postcode** |  |

|  |  |
| --- | --- |
| **Language Spoken** |  |
| **Interpreter Required** |  **YES NO** |

|  |
| --- |
| **Referrer (circle as appropriate): PARENT/CARER PROFESSIONAL** |
| **Name**  |  |
| **Telephone**  |  |
| **Email**  |  |
| **Organisation *(professionals)*** |  |

**Please select from the following options:**

1. Young person has been diagnosed with ASD and has mental health difficulties YES NO
2. Young person has been diagnosed with a Learning Disability and has mental health difficulties YES NO
3. Young person has been diagnosed with both ASD and Learning Disabilities and also has mental health difficulties YES NO
4. Young person is currently involved/has been involved with Hammersmith and Fulham CAMHS YES NO
5. Has the referral been discussed with the young person and/or their family? YES NO
6. Has the young person and/or their family agreed to this referral? YES NO

**Please detail the need for additional support around transition:**

**Please list any other agencies currently involved/involved in the past with the young person – include name of organisation and contact details:**