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 **Referral Form for the Children and Young People Gender Incongruence Services**

Young people referred to CYP-GIS are frequently struggling with issues such as communication and relationship difficulties, bullying and discrimination, low mood and anxiety, and a number also self-harm. These experiences are often linked to a young person’s gender identity.

As a national service, we believe that the local CYP-MHS/GP is best placed to monitor and manage risk, such as self-harm and suicidal ideation. CYP-MHS/GP are also in the best position to provide more regular support to the young person and their families.

**Please complete the sections in this referral form with as much information as you can to avoid delays in processing the referral. We use contact information provided by referrers to contact patients so please ensure this is up to date. We also need to know who holds parental responsibility, if we have consent for the referral from the parent/carer and to whom correspondence should be addressed (e.g. parent/carer & young person or young person only). Our preferred method of contact is email so please provide this where possible.**

If this information is not provided, we will have to follow this up with you which may delay the referral being processed.

Please note that this service only sees young people up to the age of 18. Unfortunately, we are unable to accept self-referrals from young people or their families. Please contact your GP, CYP-MHS clinician or other health, social care, or education professionals for a referral to the service.

Please send the completed form to agem.cyp-gnrss@nhs.net

|  |  |
| --- | --- |
| **Date of referral** | Click or tap to enter a date. |
| **Young Person** |
| **All correspondence should be addressed to:\*** | [ ]  Young person only (16+ only) [ ]  Legal guardian and young person | **Consent for referral from young person?\***  | [ ]  Yes [ ]  No |
| **Consent for referral from Parent(s)/legal guardian?\*)** | [ ]  Yes [ ]  No |
| **Who holds parental responsibility?\*** |  [ ]  Parents (both) [ ]  Parent (one) [ ]  Guardian  [ ]  Other | **Comments on responsibility**  |  |
| **Date of birth\*** | Click or tap to enter a date. | **NHS Number\*** |   |
| **Age at time of referral** | Years | Months | **Ethnicity\*** | Choose an item. |
|  |  |
| **Forename\*** |   | **Preferred Forename** |   |
| **Surname\*** |  | **Preferred Surname** |  |
| **Change name by deed poll?\*** | [ ]  Yes [ ]  No | **Sex assigned at birth\*** | [ ]  Female [ ]  Male |
| **Address\*** |  | **Patient’s email address**  |  |
| **Postcode\*** |   | **Patient's Mobile**  |   |
| **Member of armed forces?\*** |  [ ]  No [ ]  Unknown [ ]  Yes, ex-services member  [ ]  Yes, dependent of an ex-services member | **Patient's Telephone**  |   |
|
| **Parent/Carer 1 details**  |
| **Name\*** |   | **Relationship to patient\***  |  |
| **Address (If different to patient)\*** |  | **Telephone number\*** |  |
|  **Email Address\*** |  |
| **Parent/Carer 2 details** |
| **Name\*** |   | **Relationship to patient\***  |  |
| **Address (If different to patient)\*** |  | **Telephone number\*** |  |
|  **Email Address\*** |  |
| **Referrer:** |
| **Name\*** |   | **Job Title\***  |  |
| **Address\*** |   | **Organisation\***  |  |
| **Email address\*** |   | **Telephone Number\*** |  |
| **GP Details (If different from referrer)** |
| **GP Name** |   | **GP Practice** |   |
| **Address** |   | **GP Contact details (including email)** |   |
| **Accessible patient information requirements** |
| **Does the young person require communication support?** **Please specify**\* |    |
| **Does the young person require a specific contact method?Please specify\***  |  |
| **Does the young person require a communication professional? (i.e. interpreter) Please specify\*** |  |
| **Does the young person require a specific information format?** **Please specify\*** |  |
| **Does the young person have any identified needs? (travelling to appointments, childcare, access to internet)\*** |  |
| **For clinicians** |
| **Eligibility** |
| **Does the young person express a strong desire to be of another gender or an insistence that they are another gender?\*** | [ ]  Yes [ ]  No |
|  **If desire is shown, for how long have they felt this way?\*****Additional Comments below:** | Years | Months |
|  |  |
|  |
| **How much is this impacting on day-to-day life?\*** |
|  | *Going to school?* *Friendships?**Ability to engage in ordinary life?* *Have they made any adjustments to support their social or mental health functioning?**How are they managing their feelings about gender?* |
|  **What does the young person want to gain from the service?\*Additional comments below:** | [ ]  Therapeutic support[ ]  Managed feelings about gender[ ]  Medical intervention |
|   |
| Development |
| **Current Gender Identity (please choose one only)\*** |  [ ]  Female [ ]  Male  | [ ]  Trans Female[ ]  Trans Male | [ ]  Agender[ ]  Non-binary | [ ]  Questioning/Not Known[ ]  Other (please specify) |
| **Other comment:** |
|   |
| **Preferred pronoun(s)\*** |  |
| **Reason for Referral\***  |
|  | *Who has requested this referral?**What are their hopes for the future?*What work has already been done with the young person?*How does the young person currently describe their gender identity and feelings about this?**Parental view of the young person's gender?**Reason why the young person and/or their family want to be referred*  |
| **Gender History and Development\*** |
|  | *How has the young person's gender identity evolved over time?**History and experience of preferences for a different name or pronoun?**Has the young person made any attempts to live as their preferred gender, if yes what have they done and when?**Has there been exploration of gender and/or sexual identity in a professional context, therapeutic or otherwise?**Has the young person started puberty? What is their experience of this?* |
| **Developmental History\*** |
|  | *Pregnancy, birth, developmental milestones, attachment, communication. Family and peer relationships, feedback from nursery/pre-school/school. Any other professionals involved e.g. SALT, dietician, other.* |
| Concerns |
| **Are there risk issues? (Historic or present) and how are they being managed and by whom?\*** |
|  | *Historic or current issues of self-harm, suicide attempts or ideation**Other risk-taking behaviours (substance use, self-neglect, self medcation, sexual exploitation, digital risk) Risk to others?**Experience of domestic abuse/violence, abuse, neglect?**Have any of these required professional intervention or hospitalisation?**Who is involved in the care of the young person?**What is the current care plan? Other therapeutic support provided**Are there referrals to other agencies being considered/made?**Who is currently managing the risk for this young person?* |
| **Associated difficulties\*** |
|  | [ ]  Autism Spectrum Condition[ ]  Attention deficit hyperactivity disorder[ ]  Attention deficit disorder[ ]  Learning Disability/Difficulties[ ]  Other |  | [ ]  Somatic Symptoms[ ]  Eating Disorder[ ]  Psychosis[ ]  No Associated Difficulties |
| **Please describe indicated difficulties\*** |
|  |
| **Psychosocial context - strengths and difficulties?\*** |
|  | *- Low mood, anxiety, depression, low self-esteem**- Experience of bullying and/or discrimination, difficulty in social relationships**- How is the young person doing at school?**- Friendships/support network/ strengths and resources**- Have interventions been offered? (i.e. counselling, therapy either through CYP-MHS, School or privately, help group)* |
| **Does anyone in the family have mental or physical health issues?\*** |
|  |
| **Significant family life events and circumstances (e.g. miscarriages, separations, bereavements or migration) with dates\*** |
|  | Trauma?Family conflicts/riftsSibling difficulties? |
| **Physical Health\*** |
|  | *Ongoing and early difficulties**Significant medical conditions* |
| **Other Aspects you would like to add that have not been covered** |
|  |
| **Support** |
| **Family structure and circumstances (details of birth parents, sibling and current living arrangements)\*** |
|  | *Who does the young person live with?**If parents are separated, what are the living or contact arrangements?**Who in the family is aware of the referral? How do they feel about the young person’s gender identification?* |
| **What are the best days/times to contact you? (We may need to discuss the patients circumstances with you) \*** |  |
| **In what capacity are you seeing this patient? (i.e. frequency of appointments, length of time known)\*** |  |
| **Please outline your plans for continued involvement as well as plans to support the young person should distress increase\*** |
|  | Please outline your plans for continued support for this young person, including around their gender whilst they are waiting. |
| **Child Protection and Safeguarding** |
| **Is the child subject to a** | **If historic, please indicate when** | **Yes** | **No** |
| Child in need plan\* |  |  |  |
| Child Protection Plan. Please specify which categories?\* |  |  |  |
| Child in Care (LAC) Plan\* |  |  |  |
| Any other legal status (Children Acts, Criminal Justice, Mental Health Capacity Act)?\* |  |  |  |
| **Involvement of other agencies** |
| **CAMHS** |
| Name |  | Job Title |  |
| Organisation |  | Telephone Number |  |
| Email Address |  |
| What support is being offered? |  |
| **Volunteer Sector** |
| Name |  | Job Title |  |
| Organisation |  | Telephone Number |  |
| Email Address |  |
| What support is being offered? |  |
| **Support Group(s)** |
| Name |  | Job Title |  |
| Organisation |  | Telephone Number |  |
| Email Address |  |
| What support is being offered? |  |
| **Social Care** |
| Name |  | Job Title |  |
| Organisation |  | Telephone Number |  |
| Email Address |  |
| What support is being offered? |  |
| **Other** |
| Name |  | Job Title |  |
| Organisation |  | Telephone Number |  |
| Email Address |  |
| What support is being offered? |  |

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**Addendum to Referral form: Service Users with identified risk**

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| --- | --- |
| Patient full name: |  |
| Patient NHS Number: |  |
| Patient Date of Birth:  |  |
| Patient Address (including postcode): |  |

Thank you for your referring the above patient to the Child and Young Person Gender National Referral Service (CYP-GNRSS). This is a **non- clinical service** and therefore the responsibility for the above-named child remains with you until such a time as the referral has been reviewed by a specialist MDT and the referral accepted. **In the meantime, you should consider whether a referral is required to local services for any associated healthcare or wellbeing needs, as appropriate and that the risk is managed locally.** GPs,local Children and Young Person Mental Health Services (CYP-MHS) or therapeutic agencies are best placed to offer regular general therapeutic support and monitoring of safety whilst patients are awaiting a decision on whether the referral has been accepted by the MDT.

The questionnaire below supports the application form and is part of the overall referral form.

Please ensure that where you have indicated an identified risk below, that you have completed the actions taken or provide a rationale as to why no referral has been made.

The risk assessment will be checked for completeness by the CYP-GNRSS referral administrative team. However, as this is not a clinical or triage service, where a risk has been identified it remains your responsibility to ensure that appropriate referrals are requested via the GP or made to other agencies such as social care or CYP-MHS.

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| --- |
| **Please return completed form (alongside completed referral form) to:**Agem.cyp-GNRSS@nhs.net  |

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| **Mental Health**  |
| **Risk Identified** | **Yes** | **No** | **Action Taken** | **Yes** | **No** | **Contact details of service referred to:** |
| Self-harming behaviour – recent, history or at risk |[ ] [ ]  Referred to Child and Adolescent Mental Health Services |[ ] [ ]   |
| Mental health disorder – for example: low mood/depression, anxiety, eating disorders, PTSD |[ ] [ ]  Referred to Child and Adolescent Mental Health Services |[ ] [ ]   |
| Substance Misuse |[ ] [ ]  Referred to appropriate substance misuse support services | [ ]   |[ ]   |
| Neurodevelopmental disorders – autism, Learning disabilities ADHD |[ ] [ ]  Referred to appropriate specialist service |[ ] [ ]   |
| If you have indicated that a referral has not been made, please provide the rationale below: |  |
| **Safeguarding Risks** |
| **Risk identified** | **Yes** | **No** | **Action taken** | **Yes** | **No** | **Contact details of service referred to:** |
| At risk of abuse or maltreatment  |[ ] [ ]  Referred via Local Authority Safeguarding Team |[ ] [ ]   |
| At risk of harm to health or development |[ ] [ ]  Referred via Local Authority Safeguarding Team |[ ] [ ]   |
| Other safeguarding concerns |[ ] [ ]  Referred via Local Authority Safeguarding Team |[ ] [ ]   |
| If you have indicated that a referral has not been made, please provide the rationale below: |  |
| **Other risks** |
| **Risk identified** | **Yes** | **No** | **Action taken** | **Yes** | **No** | **Contact details of service referred to:** |
| Bullying or victimisation  |[ ] [ ]  Contact made with Local Authority Safeguarding Team for advice |[ ] [ ]   |
| Other risky behaviours – for example sexual behaviours |[ ] [ ]  Contact made with Local Authority Safeguarding Team for advice |[ ] [ ]   |
| Accessing other sources of gender treatment (on-line or private) |[ ] [ ]  Contact made with Local Authority Safeguarding Team for advice |[ ] [ ]   |
| If you have indicated that a referral has not been made, please provide the rationale below: |  |