

**Referral Form**

PLEASE COMPLETE ALL SECTIONS IN THIS 2 PAGE FORM IN BLOCK CAPITALS:

**PLEASE RETURN FORM TO:** **gems.4health@nhs.net**

Full Name and title of Parent or Carer:

Full name of Child:

DOB of child:

Childs Ethnicity:

Home Address:

Contact Telephone Number:

Email address:

Preferred method of contact: Email: Yes/No Phone: Yes/No

Childs NHS Number:

Childs GP's Name:

GP's Phone number:

GP's Address:

Parental Responsibility: Yes/no

Interpreter Required: Yes/no

Language spoken:

Current pathway: ADHD / Autism / Both

How did you hear about GEMS?

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**Other Professional involvement:**

Name and contact details of professionals involved e.g Social worker, OT, Speech and Language therapy, Pediatrician, CAMHS

**Referrer Details:**

Name of referrer:

Agency/Position:

Contact telephone number:

Reason for Referral:

Useful information (what do we need to know)

Referral discussed with the parent/carer/client: Yes/no

Has permission been granted by the parent/carer/client: Yes/no

Has consent to share information been given by the child/adult? Yes/no

What are the expected outcomes of this referral?

Signed & Dated:

For official use only

Cross Data updated by:

Signposted to :

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