

HOSPITAL YOUTH WORKER REFERRAL FORM

The Royal Alexandra Children's Hospital Emergency Department

Timescale	Date	Time
Presented CED		
Deemed Medically Fit		
Discharged		

Consent gained for referral from:

Young Person

Parent / Carer

YP home address:

Brighton & Hove

East Sussex

West Sussex

Name & Address (Or sticker)	Parent name		
	Updated Parent Mobile No.		
	Updated the Parent Contact <input type="checkbox"/>		
Tel No.	Hospital No.	D.O.B	Gender Identity

Current Location of Young Person

CED Short Stay Paediatric Ward Discharged / Home

Number of CED attendances by YP	Date of last attendance:
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Suspected / Known Neurodevelopmental Needs

Autism Learning Disorder Motor Disorder Communication Disorder

ADHD Other: N/A

Other Services Involved

CAMHS Police Social Work Youth Offending Adolescent Services

PMHLT Other: N/A

Reason(s) for Referral
(See expanded list on Hospital Youth Worker information poster)

Violence & Offending Concerns

Social Concerns

Protective Factor Concerns

Notes / Space to Expand

To complete the Referral:

1. Hand to Hospital Youth Worker
2. Leave in HYW in tray
3. Email to alexyouthworker@nhs.net

I acknowledge that a referral to the Hospital Youth Worker is not a replacement for typical safeguarding practice, nor an alternative to Paediatric Mental Health Liaison Team's interventions. <input type="checkbox"/>	Referral Made by:	Date:
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