|  |
| --- |
| **Please return this form once completed to the person making the referral to Community Paediatrics to be included with the referral form** |



Child Name……………………………………………………………………….

Date of Birth ……………………………………………………………………

Parents Name(s) ……………………………………………………………….

………………………………………………………………………………………….

**Children & Young People Services**

 **Consent and Confidentiality Form**

**Consent to Share information**

I understand that by giving my consent to proceed with a referral to the Community Paediatric service, the screening of referrals and assessment (if the child is accepted to the service) will likely involve a multidisciplinary team (MDT) of professionals who work across three different NHS trusts. The professionals will talk and share information about me in order to complete a thorough assessment, they will also access all of my historical medical records. The MDT includes Community Paediatricians (United Lincolnshire Hospitals NHS Trust), Speech and Language Therapists (Lincolnshire Community Health Services NHS Trust) and Clinical Psychologists (Lincolnshire Partnership NHS Foundation Trust).

I understand that sometimes it helps practitioners to talk with, and share information with, other people and services who are (or have been in the past) involved with me. I give consent for you to contact the following people / services:

|  |  |  |
| --- | --- | --- |
| **Service/Organisation**  | **Contact Person** **(Name and contact details)** | **Consent Given** |
| School |  | [ ] Yes[ ]  No [ ]  N/A |
| Social Worker |  | [ ] Yes[ ]  No [ ]  N/A |
| Early Help Worker |  | [ ] Yes[ ]  No [ ]  N/A |
| Child and Adolescent Mental Health Service (CAMHS) |  | [ ] Yes[ ]  No [ ]  N/A |
| Working Togther Team |  | [ ] Yes[ ]  No [ ]  N/A |
| Educational Psychologist |  | [ ] Yes[ ]  No [ ]  N/A |
| Health Visitor |  | [ ] Yes[ ]  No [ ]  N/A |
|  |  | [ ] Yes[ ]  No  |
|  |  | [ ] Yes[ ]  No  |

I am **not ok** for you to contact or share information with the following people / service

|  |  |
| --- | --- |
| **Service / Person** | **Reason** |
|  |  |
|  |  |
|  |  |

If the referral highlights concerns related to a young person’s mental health, the Community Paediatrics triage team can liaise with the CAMHS team and send the referral on for their consideration.

If the triage team consider my referral to be appropriate for CAMHS:

|  |
| --- |
| I give consent for the referral to be sent to CAMHS for their consideration [ ]  |
| I do not give consent for the referral to be sent to CAMHS for consideration [ ]  |

I understand that if you have any worries about my safety or someone else’s safety you may have to talk with someone responsible for my safety and the safety of others and share information with them without my permission. I understand that, where ever possible, you will let me know if you have to share some information with other people without my permission [ ]

**How I would like information to be shared with me**

If we access the service you have let me know that practitioners may want to send me

* Appointment details
* Letters and reports that describe what the service is offering to me
* Information to help me work on ideas that the service have shared with me

I give consent for this information to be sent to me via

[ ]  E mail………………………………………………………………Email Address

[ ]  Text message…………………………………………………….Mobile Phone

[ ]  Post

[ ]  Me picking the things up from the service buildings

[ ]  The information being sent to a person of my choice ……………………………………………..

 (name and address of person and relationship to me) ……………………………………………...

I want you to know that it helps me when written things are going to be sent to me for these to be sent

[ ]  Alternative language [ ]  Braille [ ]  Audio

[ ]  Easy read [ ]  Another way - please specify: ……………………………………

**Appointments**

I would be interested in accessing appointments via video and I know I can speak with [ ]

a practitioner to understand how a video appointment might be arranged for me.

I would be interested in accessing appointments by telephone and I know I can speak with [ ]

a practitioner to understand how a telephone appointment might be arranged for me.

**Signed Consent**

**Signed**:……………………………………… **Print**:……………………………….. **Date**:…………………..(Child/Young Person)
**Signed**:………………………………………. **Print**:………………………………… **Date**:…………………..(Parent/Carer)
Relationship to child/young person:………………………………………………………………………………..

Alternatively, if the form is being comleted electronically please confirm:

[ ]  Verbal Consent has been given by Child/Young Person

[ ]  Verbal Consent has been given by Parent/Carer

**Please let us know if you would be interested in taking part in research opportunities**

Sometimes outside orgainsations such as Universities contact the service about research opportunities. In order to continue to improve services, the quality of our assessment tools and improve support that can be offered, research is very important. Some research might include understanding young people or parent/carer experiences, some research might involve trialing interventions for mental health or behavioural difficulties.

I give consent to be contacted by email to inform me of any research that might be relevant for me to take part in.

[ ]  Yes. Email address ………………………………………………..

[ ]  No