**CYP Referral Form for CYP Gender Services**

Referrals to Children and Young People’s (CYP) Gender Services are for any child or young person up to the age of 18 years who is experiencing gender incongruence.

Children and young people seeking support from gender services may have a range of other concerns including communication and relationship difficulties, bullying and discrimination, low mood, and anxiety, and/or self-harm. Please ensure that support and risk management for presenting difficulties are put in place by services local to the child or young person. These experiences are often linked to a young person’s gender identity.

Local NHS funded CAMH and Paediatric Services have experience of monitoring and managing risk, such as self-harm and suicidal ideation. These services can provide regular support to the young person and their families under their care or direct them to appropriate local support.

The Arden and GEM Gender National Referral Support Service (GNRSS) provides the waiting list management service, on behalf of NHS England, for children and young people to access CYP Gender Services. All referrals must be completed using this form.

**Please complete all the sections in this referral form to avoid delays in processing the referral. GNRSS use contact information provided by referrers to contact patients so please ensure that telephone and email addresses are complete as well as home address. The preferred method of contact with a patient, carer or family is via email so please provide this where possible.**

**Details of parental responsibility, consent and preferred contact methods are essential. If they are not provided, then your referral is likely to be rejected.**

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

Please note that CYP Gender Services only see young people up to the age of eighteen. Referrals can only be accepted from NHS commissioned children and young people’s mental health and paediatric services.

Please send the completed Referral Form to [agem.cyp-gnrss@nhs.net](mailto:agem.cyp-gnrss@nhs.net)

**Please note that this referral form will be updated and the latest version can be found on** [National Referral Support Service for The NHS Gender Incongruence Service for Children and Young People - NHS Arden & GEM CSU (ardengemcsu.nhs.uk)](https://www.ardengemcsu.nhs.uk/services/clinical-support/national-referral-support-service-for-the-nhs-gender-incongruence-service-for-children-and-young-people/)

**CYP Referral Form for CYP Gender Services**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of referral** | | | | | | | | | Click or tap to enter a date. | | |
| **Young Person** | | | | | | | | | | | |
| **All correspondence should be addressed to:** | | Legal guardian and young person  Young person only (16+) | | | | | | **Referral consent from young person** | | | Yes  No |
| **Referral consent from Parent(s)/**  **legal guardian** | | | Yes  No |
| **Who holds parental responsibility for the young person?** | | Parents (both)  Guardian  Parent (one)  Other | | | | | | | | | |
| **Do any of the following apply?** | | Asylum seeking or an unaccompanied minor  Child in Need Plan  Child Protection Plan (specify which categories?)  Care Order  Special Guardianship  Child Arrangement Order | | | | | | | | | |
| Please add relevant information where parental responsibility is not with the parent (including details of any care orders that may be in place) | |  | | | | | | | | | |
| **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** | | |  |
| **Pronouns preferred by child or young person** | |  | | | | | | **Natal sex** | | | Female  Male |
| **Patient’s address** | |  | | | | | | **Postcode** | | |  |
| **Patient’s email** | |  | | | | | | **Telephone** | | |  |
| **Parent/Carer 1 Name** | |  | | | | | | **Relationship to patient** | | |  |
| **Address  (If different to patient)** | |  | | | | | | **Telephone** | | |  |
| **Email** | |  | | | | | | | | | |
| **Parent/Carer 2 Name** | |  | | | | | | **Relationship to patient** | | |  |
| **Address  (If different to patient or Parent/Carer 1)** | |  | | | | | | **Telephone** | | |  |
| **Email** | |  | | | | | | | | | |
| **Details of living arrangements if not with parents** | |  | | | | | | | | | |
| **GP Name** | |  | | | | | | **GP Practice** | | |  |
| **GP Postal and email address** | |  | | | | | | **GP Telephone** | | |  |
| **Referrer Organisation** | | | | | | Choose an item. | | | | | |
| **Referrer Name** |  | | | | | **Job Title** | | |  | | |
| **NHS Trust** |  | | | | | **Service Name** | | |  | | |
| **Address** |  | | | | | **Postcode** | | |  | | |
| **Referrer’s email** |  | | | | | **Telephone** | | |  | | |
| **Date of referral to your service** |  | | | | | **Date of first appointment** | | |  | | |
| **Reason for Gender Service referral including gender history and social transition situation** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Gender identity (please choose only one) | | | | | | | | | | | |
| Agender | Non-binary | Questioning/  Not known | | | | Male to Female | | Female to Male | | | Other (please detail below) |
| **Associated conditions** | | | | | | | | | | | |
| ☐ Anxiety  ☐ Attention deficit disorder  ☐ Attention deficit hyperactivity disorder  ☐ Autism  ☐ Body dysmorphia  ☐ Eating Disorder  ☐ Learning Disability/Difficulties | | | | | ☐ Low mood or Depression  ☐ OCD  ☐ Other (please detail below)  ☐ Psychosis  ☐ PTSD  ☐ Somatic Symptoms or medically unexplained  ☐ Trauma | | | | | | |
| **Details of any physical disabilities, physical health, medical conditions, neurodevelopmental or mental health difficulties** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Medication history** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Significant life events or experiences where relevant** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Mental Health risk/s identified** | | | **Yes** | **No** | | **Details if yes ticked** | | | | | |
| Relevant to gender incongruence | | |  |  | |  | | | | | |
| Risk to health and development | | |  |  | |  | | | | | |
| Risk to self | | |  |  | |  | | | | | |
| Risk to others (including potential risk to staff) | | |  |  | |  | | | | | |
| Risk from others | | |  |  | |  | | | | | |
| Risk of eating disorder | | |  |  | |  | | | | | |
| Risk of deterioration in mental health (including psychosis) | | |  |  | |  | | | | | |
| Other | | |  |  | |  | | | | | |
| **Safeguarding risk/s identified** | | | **Yes** | **No** | | **Details if yes ticked** | | | | | |
| Safeguarding concerns | | |  |  | |  | | | | | |
| Open to/Referral made to Children’s Social Care | | |  |  | |  | | | | | |
| **Any other risk/s identified** | | | **Yes** | **No** | | **Details if yes ticked** | | | | | |
| Bullying or victimisation | | |  |  | |  | | | | | |
| Risk due to social transition (current or future) | | |  |  | |  | | | | | |
| Behaviours that make the young person more vulnerable to harm | | |  |  | |  | | | | | |
| Accessing other sources of gender treatment (on-line or private) | | |  |  | |  | | | | | |
| Other | | |  |  | |  | | | | | |
| **Additional Needs** | | | **Yes** | **No** | | **Details if yes ticked** | | | | | |
| Do they require communication support? | | |  |  | |  | | | | | |
| Do they require an interpreter? | | |  |  | |  | | | | | |
| Are they fully accessing education and/or employment | | |  |  | |  | | | | | |
| Do they have an Educational Health & Care Plan (EHCP)? | | |  |  | |  | | | | | |
| **Details of above if ticked** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Children’s Social Care Involvement** | | | | | | | | | | | |
| Name | | |  | | | | Job Title | | |  | |
| Organisation | | |  | | | | Telephone Number | | |  | |
| Email | | |  | | | | | | | | |
| What support is being offered? | | |  | | | | | | | | |
| **CYP Mental Health Service contact details, if not the referrer** | | | | | | | | | | | |
| Name | | |  | | | | Job Title | | |  | |
| Organisation | | |  | | | | Telephone Number | | |  | |
| Email | | |  | | | | | | | | |
| What support is being offered? | | |  | | | | | | | | |
| **Any other professional or agency involvement** | | | | | | | | | | | |
| Name | | |  | | | | Job Title | | |  | |
| Organisation | | |  | | | | Telephone Number | | |  | |
| Email | | |  | | | | | | | | |
| What support is being offered? | | |  | | | | | | | | |