CHILDREN & YOUNG INITIAL CONTACT FORM

Agency Referring:		Date:	
Are you or your client currently being seen by another agency?			Please tick:
	CAMHS		
	Social Work Team		
	Motivate		
	Moving On project		
	EIP		
	Children's Services		
	Other (please state below):		

NAME AND TITLE OF CLIENT:					
Address:		Tel No:		Gender:	
		Message OK:	Yes / No		
		Origin:	Walk In / Phone / Email / Letter / Website		
Postcode:		Email Address:			
Date of Birth:	Current Age:	Referral Type:			
GP Name:		Name of GP Surgery:			
Ethnic Background:					
Name of School:					

Form continues overleaf

Why have you contacted us today? (A synopsis of client needs and background):	
Have you or your client approached a GP regarding these needs?	Yes / No
What was the advice given by the GP?	
Have you or your client been given medication?	Yes / No
Have you or your client received help from Upturn before?	Yes / No
Have you/your client ever been Violent or aggressive?	Yes / No
If yes, please provide details:	
Do you/your client have a learning disability?	Yes / No
If yes, please provide details:	
You/your client will receive a phone call from one of our Upturn workers. Please provide contact details and times that are best for you:	