**Privacy Notice**

The MHST is required to hold information about the child/young person/family following a consultation. They will keep the information safe. Only Barnardo’s staff will use this information however, sometimes they may need to share some to protect the best interests of CYP.

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| **Time and date of consultation** | Date:  Time: |
| **Education Setting** |  |
| **Person/people attending consultation** | MHST Practitioner:  School staff/CYP/Family: |

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| **CYP Name** |  | | | |
| **DOB** |  | | | |
| **Gender** | Male  Female | | | |
| **Is gender the same as that assigned at birth?** | Yes  No  If not, please provide further details: | | | |
| **CYP Contact**  **Details** | Email:  Mobile: | | | |
| **Ethnicity** | White  Black  Asian  Mixed  Chinese  Other: | | | |
| **Communication needs** | (E.g., interpreter required, other adaptations) | | | |
| **Physical Health needs** | (**Allergies**, relevant health conditions to be aware of) | | | |
| **SEND** | EHCP: Y  N | Learning Needs: | Disability: Y  N |  |
| **Child Looked After** | No  Yes | | | |
| **Child Protection Plan** | No | Yes | Historic |  |
| **Consent from CYP** | Yes  No | | | |
| **Consent from parents/carers** | Yes  No | | | |
| **Parents/carers names and contact details** | Name: Relationship to CYP:  Phone number: Email address:  Name: Relationship to CYP:  Phone number: Email address: | | | |
| **Address** |  | | | |
| **GP Practice** |  | | | |
| **Other service’s involvement** | (E.g., mental health, early help, educational psychology, social care, school nursing) | | | |

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| **Please indicate if the child/young person is experiencing any of the following difficulties:** |
| **\*Primary Reason for referral**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Other difficulties**:  Low Mood/Withdrawal  Worry/fear/anxiety  Negative Thinking  Low self-esteem and confidence  Emotional regulation  Problem Solving Difficulties  Phobias  Anger management  Obsessive Compulsive Behaviours  Significant Life Events  Autistic Spectrum Condition (ASC) |
| **What are the current emotional health difficulties?** Presenting problem (what is going on for the child/YP, how is this manifesting, what are people around seeing? What is the child/YP saying?) |
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| **How is the child/YP functioning across these areas?** (Impact of the problem) |
| Home:  School:  Socially: |
| **Are there any mental health risks for the CYP, current or historic?** |
| Risk to self (e.g., self-harm, suicidal ideation, plan)  Risk to others  Risk from others (safeguarding concerns) |
| **What interventions have already taken place? What was the outcome? (If known)** |
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| **What help and support does the child want?** |
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| **What help and support do the key adults want for the child?** |
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| **MHST Practitioner’s thoughts and recommendations** |
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