**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 othersRisk 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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