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| **Child/Young Person’s Details** |
| **Name:**  | **Address:**  |
| **Gender:**  |
| **Date of Birth:**  |
| **Contact No.:**  |
| **Nationality:**  |

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| **Parents Details** |
| **Name:**  | **Address:** |
| **Gender:**  |
| **Date of Birth:**  |
| **Contact No.:**  |
| **Nationality:**  |

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| **Consultant Psychiatrist** |
| **Name: Dr.**  | **Address:**       |
| **Contact No.:**  |
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| **CAMHS Key Worker** |
| **Name(s):**  | **Job Title(s):**  |
| **Address:**  | **Phone Number:** |

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| **Checklist for discharge** |
| Closure completed on Chart |  |
| Closure completed on system  |  |
| HONOSCA completed  |  |
| Young person and parent/carer advised to attend GP in 2 weeks for review |  |
| Relapse and protective factors discussed with young person & parent/carer |  |
| Closing Discharge Summary Form completed  |  |
| Planned Case Closure recorded at weekly MDT meeting  |  |
| Signatures on Closing Discharge Summary Form and dates  |  |
| Copy of Closing Discharge Form forwarded to GP  |  |
| Copy of Closing Discharge Form forwarded to Referrer, if not GP |  |
| Closed files to be filed in designated storage  |  |

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| **Key Worker:**  |  | **Discipline:** |  |
| **Signed:** |  | **Date:** |  |