Webster Stratton Referral Form

Child's Name: Date of Birth:

School:

Parents' Names:

Address:

Tel Number:

Email address:

Parents' Ethnicity: Parent's Home Language:

Do they require an interpreter: Yes □ No □

Number of other children in the family and their ages:

How many children may require crèche facilities?

GP Name & Address:

Does the parent have a disability? Yes □ No □ Not Known □

Please give details:

Please confirm that you have discussed this referral with the parent and comment on their views:

What are the main reasons for this referral?

What other agencies are involved with this family ?

Is this child identified as a Child in Need Yes □ No □ or

Subject to a Child Protection Plan Yes □ No □

Who is the named social worker ? ……
Please give brief details:

 I agree to this referral and understand that my details will be kept on an electronic database and shared with other relevant professionals.

 I understand that my GP and referrer will get a copy of the invitation letter and brief summary at the end of the course.

Signature …….. Date ……...

Name of referrer & full address please:

Signature…… Date ..……..

Please return this form to CAMHS H-Block , St Ann's Hospital, St Ann's Road, London N15 3TH Tel: 0208 702 5154 or

email: beh-tr.camhsreferral@nhs.net