

# Lighthouse Child Development Centre Tics & Tourette’s Disorders Service Referral Form

We provide specialist assessments of tics and offer medication advice and specific interventions for tic disorders. We accept referrals for psychological interventions for tics.

Date of referral:

About the referrer:

|  |  |
| --- | --- |
| **Name** |  |
| **Professional role** |  |
| **Organisation** |  |
| **Contact number** |  |
| **Contact email** |  |

About the child/young person:

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **DOB** |  |
| **School name** |  |
| **School year** |  |

Aside from your service, which other services are already involved in the patient’s care?

*Please tick the relevant box/boxes and indicate the details of the relevant professional(s) and service(s) in the space below.*

|  |  |  |
| --- | --- | --- |
| Paediatrics | ☐ | Contact person & details: |
| CAMHS | ☐ | Contact person & details: |
| Social services | ☐ | Contact person & details: |
| Other | ☐ | Contact person & details: |
| If other, please specify: | | |

Reason for referral (tick all applicable):

|  |  |
| --- | --- |
| Diagnostic second opinion | ☐ |
| Recommendations for intervention | ☐ |
| Medication advice | ☐ |
| Access to psychological interventions for tics | ☐ |
| Please indicate here more detail on the reasons for referral, including: concerns; risk; duration of the presenting problem. | |

Tell us about the young person’s tics:

|  |  |
| --- | --- |
| Onset |  |
| Nature |  |
| Frequency |  |
| Severity |  |
| Impact |  |

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Does the young person have any medical problems? Yes ☐ No ☐

*If yes, please specify:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there any of the following co-**  **occurring diagnoses?** |  |  | **Are there any of the following co-occurring**  **concerns?** |  |
| Intellectual disability | ☐ | Possible learning difficulty/intellectual disability | ☐ |
| Specific learning disorder (e.g. dyslexia) | ☐ | Possible ADHD | ☐ |
| ADHD | ☐ | Possible Autism Spectrum Disorder | ☐ |
| Autism Spectrum Disorder/Condition | ☐ | Possible OCD | ☐ |
| OCD | ☐ | **Possible Anxiety** | ☐ |
| **Anxiety** | ☐ | **Possible Depression/low mood** | ☐ |
| **Depression** | ☐ | **Possible Self-Harm** | ☐ |
| **Self-Harm** | ☐ | **Challenging behaviour** | ☐ |
| Other | ☐ | Other | ☐ |
| ***If other, please specify:*** |  | ***If other, please specify:*** |  |

What is your current formulation/working diagnosis?

What interventions have already been tried for tics?

What interventions have already been tried for co-occurring concerns and diagnoses?

Please attach your clinical assessment letter and reports or provide additional relevant details below about **family, social and developmental history.**

***Please note that we are a consultation service only and will not take over the care of young people referred to us. Local services remain the first port of call in emergencies. For referrals where there are mental health needs, we require referrals to be made by CAMHS/ EWMHS as they will remain the primary service responsible for the young person’s mental health.***

|  |  |
| --- | --- |
| **This is a referral from Paediatrics** | ☐ |
| *If ticked, please specify:* | ☐ |
| **This young person is not known to CAMHS** | ☐ |
| **This young person is known to CAMHS as detailed above** | ☐ |
| **This is a referral from CAMHS** | ☐ |

***In some instances where mental health needs are of significant concern, we will offer joint consultation to CAMHS only.*** In this case, please indicate below the name and contact details of a team member willing to attend joint assessment on a Wednesday or Thursday morning:

|  |  |
| --- | --- |
| Name |  |
| Contact telephone |  |
| Contact email |  |