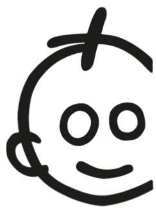

NHS
Great Ormond Street
Hospital for Children
NHS Foundation Trust

GOSH Tic Service Referral Form

We provide specialist assessments for severe and complex presentations of tics and offer medication advice and specific interventions for tic disorders. We accept referrals for second opinions on diagnosis, medication queries and psychological interventions for tics**. Please note that by making this referral you are aware and agree that the patient needs to remain under the care of your team until we discharge them from the Tic Service.**

Date of referral:

About the referrer:

Name	
Professional role	
Organisation	
Contact number	
Contact email	

About the child/young person:

Name	
Address	
DOB	
Ethnicity	
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	

GOSH Tic Service Referral Form

Have you considered functional tics in your diagnosis/formulation? Yes ☐ No ☐

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

If yes, please specify:

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

Are there any of the following co-occurring concerns?	
Possible learning difficulty/intellectual disability	☐
Possible ADHD	☐
Possible Autism Spectrum Disorder	☐
Possible OCD	☐
Possible Anxiety	☐
Possible Depression/low mood	☐
Possible Self-Harm	☐
Challenging behaviour	☐
Other	☐
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	

Please email referral form to CAMHSSecretaries@GOSH.NHS.UK for the Tic Service