

Continuing Care Transition Early Notification Form

YOUNG PERSON DETAILS

First name		Surname	
Date of Birth		Age	
Gender		Ethnicity	
Disability/Diagnosis			
NHS number			
Care Track Number			
Originating GP** name/address			
Current GP Name/address			
School			
EHCP	Yes	No	Review Date
Looked After Child	Yes	No	Date LAC
Continuing Care	Yes	No	Don't know
Section 117	Yes	No	Date Section 3
DOLs	Yes	No	In Process

**GP at the point of becoming looked after

CURRENT PACKAGE

Start date			
Provider			
Carer/Nurse			
Weekly Package			
	Night hours	Day hours	Total Cost
Social Care			
Health			
Education			
Total			

Further Information

YOUNG PERSON HISTORY (Attach/Embed any relevant documents)

FURTHER INFORMATION

Social Care

Social Care Team	
Social Worker	

Health

CAMHS Professional	
Continuing Care Nurse	
Other health professional	

Education

Education contact (if known)	
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EARLY NOTIFICATION

Date Sent		Sender name	
Date received		Receiver Name	

OUTCOME

Unlikely to meet CHC	Likely to meet CHC	Don't know