

Email\* completed referrals to [**SNHS.CAMHSWestNewReferrals@nhs.net**](mailto:SNHS.CAMHSWestNewReferrals@nhs.net)

**Consultation line** – 0300 123 6661 (Triage Team)

If an urgent referral, please contact us on the above number– We accept referrals and self-referrals over the telephone via our Duty or Triage Team

**\*Disclaimer:** Please be aware that sending by email from iCloud, Gmail, Hotmail, Live, Yahoo or other private email accounts to NHS.net is not secure. If you would prefer to send the referral form via post please send it to the relevant postal address given at the end of the document

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| Child & Adolescent Mental Health Service – Referral Form | | | | | | | | | | | |
| Young Person Details | | | | | | | | | | | |
| **Forename** | |  | | | | | | | **Surname** |  | |
| **Also known as** | |  | | | | | | | **Date of Birth** |  | |
| **Gender** | |  | | | | | | | **NHS No.** |  | |
| **Address at which the child/young person is currently living** | |  | | | | | | | | **Landline / home telephone number** | |
| **Child/young person mobile number** | |  | | | | | | | **Parent’s/Carer’s mobile number** |  | |
| **Is the Child / Young Person: (tick all that apply) –** | | | | | | | | | | | |
| □ Living with parents | | □ Living with relatives | | | | | | | | □ Other (please state) | |
| □ Looked After Child | | □ Subject to a Child Protection Plan | | | | | | | | □ Adopted | |
| First language: | | | | Interpreter required? □ Yes □ No  If yes, which language? | | | | | | | |
| Does the child/young person consider themselves to be transgender?  □ Yes □ No | | | | Sexual orientation:  □ Heterosexual □ Gay  □ Lesbian □ Bisexual □ Prefer not to say | | | | | | | |
| Does the child / young person have a disability?  □ Yes □ No  If Yes, Please specify: | | Does the child / young person have a  Visual impairment □ Yes □ No  Hearing impairment □ Yes □ No | | | | | | | | Is the child / young person a Young Carer?  □ Yes □ No | |
| **Name of GP** | |  | | | | | | | **GP surgery name** |  | |
| GP surgery telephone number and email address | |  | | | | | | | GP surgery address: |  | |
| **Ethnicity** | | □ White British | | | □ Irish | | | | | □ Gypsy or Irish Traveller | |
| □ White and Black Caribbean | | | □ White and Black African | | | | | □ White and Asian | |
| □ Indian | | □ Pakistani | | | □ Chinese | | | | | □ Bangladeshi | |
| □ Any other Asian background | | □ African | | | □ Caribbean | | | | | □ Other Black/Caribbean/African Background | |
| □ Arab | | □ Any other ethnic group – please state | | | | | | | |  | |
| □ Any other mixed / multiple ethnic background – please state | | | | | | | | | | | |
| **Religion** | | □ Agnostic □ Atheist □ Baha’I □ Buddhist □ Chinese (Taoist / Confucian)  □ Christian □ Hindu □ Humanist □ Japanese (Shinto) □ Jewish □ Jainism  □ Muslim □ Pagan □ Rastafarian □ Sikh □ Spiritualist  □ Do not wish to disclose □ Other | | | | | | | | | |
| PARENT/CARER DETAILS | | | | | | | | | | | |
| **Who holds parental responsibility for the child /young person?** | | | | | | | | | | | |
| Forename | |  | | | Surname | | | | |  | |
| Relationship | |  | | | Telephone number | | | | |  | |
| Address | |  | | | | | | | | | |
| **Is there any history of parental mental health difficulties and/or history of substance misuse?** □ Yes □ No | | | | | | | | | | | |
| If yes, please provide details: | | | | | | | | | | | |
| Are there any adult services currently involved? □ Yes □ No | | | | | | | | | | | |
| If yes, please provide details: | | | | | | | | | | | |
| SAFEGUARDING | | | | | | | | | | | |
| Please tick all relevant boxes | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | History of Domestic Abuse |  | Safeguarding children issues (present & historical) |  | | Substance Misuse (including partner) |  | Social Services involvement (present & historical) |  | | Alcohol Misuse (including partner) |  | Any other relevant social factors |  | | Social/Safeguarding history not known |  |  |  | | | | | | | | | | | | |
| Name of Allocated Social Worker or Family Support Worker | | |  | | | | | | | | |
| Children’s Services Team | | |  | | | | | | | | |
| Address | | |  | | | | | | | | |
| Telephone | | |  | | | | | | | | |
| EDUCATION / NOT IN EDUCATION (NEET) | | | | | | | | | | | |
| Name of School/College: | | | | | | | School/College address and telephone number: | | | | |
| Home school / Tutor: | | | | | | | Please give details: | | | | |
| MENTAL HEALTH NEEDS AND CONCERNS | | | | | | | | | | | |
| **Reasons for Referral –**  Please state nature of mental health difficulties, onset, frequency and duration, current presenting risk, interventions tried, impact on child and family, impact on education, and any relevant medical history: | | | | | | | | | | | |
| **What services have been accessed already?** | | | | | | | | | | | |
| **Expectations of Referrer:** (What would you like to happen as a result of this referral? What is your best outcome? It may help to include your/your agency’s involvement with the family and details of any progress) | | | | | | | | | | | |
| **Results of the Young Person’s physical check □ Satisfactory □ Unsatisfactory** | | | | | | | | | | | |
| Height |  | | | | | | | Hearing | | |  |
| Weight |  | | | | | | | Eyesight | | |  |
| Blood Pressure |  | | | | | | | Medications | | |  |
| Pulse |  | | | | | | |
| Cardiovascular Check |  | | | | | | | Other Diagnoses | | |  |
| **Young Person’s view of the referral and their strengths:** | | | | | | | | | | | |
| **Are there any concerns relating to substance misuse?** □ Yes □ No If Yes, please provide details: | | | | | | | | | | | |
| **Are there any concerns relating to food/weight/suspected eating disorder?** □ Yes □ No If Yes, please provide details : (current height, weight, history of weight loss, physical symptoms, current eating pattern and behaviours) | | | | | | | | | | | |
| REFERRER DETAILS | | | | | | | | | | | |
| Name | |  | | | | Job Title/Profession: | | | |  | |
| Address | | | | | | | | | | | |
| Post Code: | | | | | | Telephone: | | | |  | |
| Date of Referral | |  | | | | Email address | | | |  | |
| REFERRAL CONSENT (Referral must be discussed with the young person before submission) | | | | | | | | | | **If no, please give reason** | |
| Does the Parent/Carer know about the referral? | | | | | Yes | | | | No |  | |
| Does the Parent/Carer consent to the referral? | | | | | Yes | | | | No |  | |
| Does the Child/Young Person know about the referral? | | | | | Yes | | | | No |  | |
| Does the Child/Young Person consent to the referral? | | | | | Yes | | | | No |  | |
| Do we have your permission to share information with any other family member? | | | | |  | | | |  |  | |
| Do we have permission to send text messages/text message appointment reminders | | | | | Yes | | | | No | If Yes, please write the mobile phone number here: | |
| FORWARDING CONSENT | | | | | | | | | | If no, please give reason | |
| Does the Child/Young Person/Carer give consent to forward the referral to the appropriate external agency e.g. Children’s Services, Education, Voluntary sector? | | | | | Yes | | | | No |  | |

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| Signed………………………………………… |  | Date………………………………… |
| Title Role: ………………………………………………………………………………………….. | | |
| **Postal address for referrals:** |  |  |
|  |  |  |
|  |  | CAMHS West SPA Team  Child and Family Services  1st Floor Horizon  Western Community Hospital Campus  William Macleod Way  Millbrook  Southampton  SO16 4XE |