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| **PLEASE PRINT CLEARLY**  **Name of Child Young Person:**  **Date of birth: NHS No** (if known)  **Address**  **Post Code**  **Contact Telephone Number** \*Important\* (Please provide)  If you have any doubt about this referral or need help to complete it please contact a member of the Team and we would be happy to help you.  Confidentiality:  If you are a professional please discuss this referral with the child/young person and their parent(s) or carer(s). It may be necessary to share some information with other professionals so that we can offer the best service to the family.  During the course of their care some details may be recorded on computer. For your protection, the use of this data is controlled in accordance with the Data Protection Act, 1998. | |
| **Referrer Details:**  Name of Referrer:  Title / Role:  Agency Address & Telephone Number: | **GP Details:**  GP Name:  Surgery:  Telephone Number: |
| **Family Details:** (Please include family members in the household, full names & dates of birth/age, who has parental responsibility/prime carer)  **College / School / Nursery: (Please include address & telephone number)**  **Current Agencies Involved:**  **Presenting Concerns:** (Please Focus on Mental Health Concerns)  **Any previous CAMHS involvement:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **FOR SUSPECTED EATING DISORDER REFERRALS, PLEASE COMPLETE BELOW:**  **Weight and eating history,including details of any compensatory behaviour** (such as purging, excessive exercising):  **Current height and weight** (no shoes, light clothing):  **Any previous known heights and weights:**  **Puberty and menstruation history:**  **Medication:**  **Details of any significant past medical history:**  For young people who are significantly restricting their eating, display marked weight loss or report regular purging, the following to be actioned by GP and forwarded on to CAMHS:   * Results of physical examination, particularly: ~   + - Blood pressure and pulse, sitting and standing.     - Temperature.     - Cold extremities. * Results of investigations, particularly: ~   FBC, U+E, LFT, TFT, ESR, magnesium, calcium, phosphate, zinc, thiamine, glucose, iron, albumin, creatine kinase, coeliac screen  **Expectations of Referrer:** (What would you like to happen as a result of this referral? What is your best hope? It may help to include brief details of your involvement/your agency’s involvement with the family & progress)  **Expectations of Family/Young Person:** (What do the family/young person hope will happen as a result of this referral?)  **Additional helpful information:**  (Please include details of any CP Plans, CIN Plans on any children living in the household, whether a CAF has been completed or a TAC meeting has taken place etc. Attach copies if necessary).  **Consent gained:** (Referral must be discussed with parent/young person first)    **Have the parent agreed to referral Yes**  **No**  **Have you seen the child/young person Yes  No** | |
| **Signed:** | **Date:** |
| **Title / Role:** | |

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| **If Using SystmOne:** Please send this form to the following task recepient  3 CAMHS SPA e-Referral |
| **If Not Using SystmOne:** Please send this form to:  [SNHS.CAMHS-general@nhs.net](mailto:SNHS.CAMHS-general@nhs.net) |
| **For Further Advice, Please Contact Us On**: Tel No: 0300 123 6632  CAMHS Solent East, Falcon House, St James Hospital, Locksway Road, Portsmouth PO4 8LD |