

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

**Consultation line** – 023 81030061 (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** | | | | |  | | | | | | | | | | | | | | |
| **Preferred pronoun**  **He/Him**  **She/Her**  **They/Them** |  | | **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) | | | | | | | | | | | | | | | | | |
| □ Child Looked After | | □ Subject to a Child Protection Plan | | | | □ Adopted | | | | | | | | | | | | | | | | | |
| First language: | | Interpreter required? □ Yes □ No  If yes, which language? | | | | | | | | | | | | | | | | | | | | | |
| Does the child/young person identify themselves to be transgender?  □ Yes □ No | | Sexual orientation: Gender (please give details)  □ Heterosexual □ Gay  □ Lesbian □ Bisexual □ Prefer not to say  □ Other | | | | | | | | | | | | | | | | | | | | | |
| 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 □ None | | | | | | | | | | | | | | | | | | | | | | |
| PARENT/CARER DETAILS | | | | | | | | | | | | | | | | | | | | | | | |
| **Who holds parental responsibility for the child /young person?** | | | | | | | | | | | | | | | | | | | | | | | |
| Forename:  **Parent/Carers preferred pronoun**  He/Him  She/Her  They/Them |  | | | Surname: | | | | | | | | | |  | | | | | | | | | |
| Relationship: |  | | | Telephone number: | | | | | | | | | |  | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | | | | | |
| Forename: Surname:  Relationship: Telephone number:  Address: | | | | | | | | | | | | | | | | | | | | | | | |  |
| **NAME OF ALLOCATED SOCIAL WORKER OR FAMILY ENGAGEMENT WORKER:** | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | |  | | | | | | |
| Address | | | | | | | | | | | | | | | | |  | | | | | | |
| Telephone | | | | | | | | | | | | | | | | |  | | | | | | |
| EDUCATION / NOT IN EDUCATION (NEET) | | | | | | | | | | | | | | | | | | | | | | | |
| Name of School/College: | | | | | | School/College address  and telephone number: | | | | | | | | | | | | | | | | | |
| Home School/Tutor: | | | | | | Please give details: | | | | | | | | | | | | | | | | | |
| **EDUCATION** | | | | | |  | | | | | | | | | | | | | | | | | |
| Name of School/College: | | | | | | School/College address  and telephone number: | | | | | | | | | | | | | | | | | |
| 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:  Known to previous or current CAMHs service? Yes No  If yes please give name/address of CAMHs service | | | | | | | | | | | | | | | | | | | | | | | |
| **What services have been accessed already and what has been the impact?** | | | | | | | | | | | | | | | | | | | | | | | |
| **Expectations of Family/YP/Child/Carer:**  (What would you like to happen as a result of this referral? What is your best outcome?)  **Young Person’s view of the referral and their strengths:** | | | | | | | | | | | | | | | | | | | | | | | |
| **Results of the Young Person’s physical check: □ Satisfactory □ Unsatisfactory** | | | | | | | | | | | | | | | | | | | | | | | |
| Height |  | | | | | | | | Hearing | | | | | | | | | | |  | | | |
| Weight |  | | | | | | | | Eyesight | | | | | | | | | | |  | | | |
| Blood Pressure |  | | | | | | | | Medications | | | | | | | | | | |  | | | |
| Pulse |  | | | | | | | |
| Cardiovascular Check |  | | | | | | | | Other Diagnoses | | | | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| SAFEGUARDING | | | | | | | | | | | | | | | | | | | | |
| **Please tick all relevant boxes and include information below:** | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Adult concerns:**  Historical or current parental/carer mental health: |  | **Safeguarding children/young people concerns:**  (to include impact of substance misuse, domestic abuse, mental health, sexual exploitation etc  Current concerns: |  | | Historical or current Domestic Abuse: |  | Risk factors: |  | | Historical or current Substance Misuse (including partner or significant other in household): |  | Protective factors/strengths |  | | Historical or current involvement from Adult Social/Safeguarding Team |  | Impact on Child/YP and others? |  | | Parental capacity to manage risk: |  |  |  | |  |  | Current plan and actions |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **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 | Name | | | | | | | | | | Name | | | | | | | | |  | | | |
| Address | | | | | | | | | | | | | | | | | | | | | | | |
| Post Code: | | | | | | | | | | | | Post Code: | | | | | | Post Code: | | | | | |
| Date of Referral | Date of Referral | | | | | | | | | | | Date of Referral | | | | | |  | | | | | |
| REFERRAL CONSENT (Referral must be discussed with the young person before submission) | | | | | | | | | | | | | | | | | | REFERRAL CONSENT (Referral must be discussed with the young person before submission) | | | | | |
| 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? | | | | | | | | | | | | | Yes | | | No | |  | | | | | |
| Do we have permission to send text messages/text message appointment reminders?  Has consent been discussed/agreed for CAMHS to contact Children’s services, education and/or any other agency that are working with the family? | | | | | | | | | | | | | Yes  Yes | | | No  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 | |  | | | | |

|  |  |  |
| --- | --- | --- |
| 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 |