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**Wellbeing Hub can be contacted on; 023 81 030061**

**BRS Informal Telephone discussions** – **023 80834430**

If an urgent referral, please contact us on the above number.

Please note: BRS are only able to accept referrals from professionals from Health, Education or Social care

**\*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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| Wellbeing Hub referral reviewed by CAMHS/BRS/No Limits/Yellow Door | | | |
| Young Person Details | | | |
| **Forename** | **Surname** |  | |
| **Also known as…** | **Date of Birth** |  | |
| **Preferred pronoun**  **He/Him**  **She/Her**  **They/Them** | **NHS No.** |  | |
| **Care Director Number:** |  | |
| **Address at which the child/young person is currently living** | **Landline / home telephone number** | | |
| **Child/young person 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 |
| Are there restrictions in family contact and sharing information – i.e address of family / carers  Details: | | | |
| First language: | Interpreter required? □ Yes □ No  If yes, which language? | | |

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| Young Person Details Continued | | | |
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| 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/ SEN diagnosis?  □ 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  □Mixed British | □ Irish | □ Gypsy or Irish Traveller |
| □ White and Black Caribbean | □ White and Black African | □ White and Asian  □ Other White background |
| □ Indian or British Indian | □ Pakistani or British Pakistani | □ Chinese | □ Bangladeshi or British 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 | | |

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| PARENT/CARER DETAILS | | | |
| **Who holds parental responsibility for the child /young person? If LA hold PR – name of Foster Carer and Social worker** | | | |
| Forename:  **Parent/Carers preferred pronoun**  He/Him  She/Her  They/Them | Surname: | **Foster carer**;  Forename:  Surname:  Address: | |
| Relationship: | Telephone number: | | Mobile number: |
| Address: |  | | |
| Are their any known restrictions on sharing communication with parent(s) or caregivers. For example letters being sent.  Mother  Father  Other parent  Other caregiver  Any necessary detail:…………………………………………………………………………. | | | |

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| **NAME OF ALLOCATED SOCIAL WORKER OR FAMILY ENGAGEMENT WORKER / OTHER KEY PROFESSIONALS (required for BRS referral only)** | |
| Lead Professional | |
| Address | |
| Telephone | |
| Other Key Professionals & Agency contact details | |
| EDUCATION | |
| Name of School/College: | School/College address  and telephone number: |
| Home School/Tutor: | Please give details: |

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| MENTAL HEALTH / THERAPEUTIC NEED | | |
| **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:  Please comment on any significant life events or any difficulties in the child/YP’s history e.g. parental relationship breakdown, domestic violence, sexual abuse, missing episodes, exploitation, other contextual safeguarding risks  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?** Please comment on previous and current interventions provided | | |
| **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 |
| **Blood Results:** | | |

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| 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: | | | |
| Date of Referral | Date of Referral | | |

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| 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 |  |

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