### Child and Adolescent Mental Health Services Referral Form

Please indicate which service you are referring to by ticking the relevant box

|  |  |  |
| --- | --- | --- |
| **First Steps: Early Intervention & Community Psychology Service** | Mild to moderate mental health problems, early**, short term (6 sessions)** intervention for psychological problems including parenting programmes.First Steps do not see families who are currently working with Children’s Social Care.**Response Times - 2 weeks** | Telephone: 020 7014 7135 Fax: 020 7014 7251Email: huh-tr.FirstSteps@nhs.netReferral for First Steps [ ]  |
| **Specialist Child and Adolescent****Mental Health Service** | Serious risk to emotional and psychological wellbeing and development where difficulties are urgent, persistent, complex or severe.**Response times - 5 weeks unless an emergency/urgent** | Tel: 020 3222 5600 Fax: 020 3222 5792Email: elt-tr.cityandhackneycamhs@nhs.netReferral for Specialist CAMHS [ ] Referral for Eating Disorder Specialist CAMHS [ ]  |
| **CAMHS Disability Service** | Diagnostic Assessment and interventions for children with moderate to profound learning disabilities and developmental disorders. **Response times – 5 weeks unless risk** | Telephone: 0207 014 7071 Fax: 0207 014 7239Email: huh-tr.camd@nhs.net Referral for CAMHS Disability Service [ ]  |

If you have any queries or wish to discuss the referral please call the appropriate team on the number above

If after consideration we feel another service is more suited to the referral we will arrange for this to be passed on and will let you know between these three providers as part of the CAMHS Alliance.

|  |
| --- |
| INFORMATION about Referred Person: |
| Surname: |  | Forenames: |  |
| Date of Birth:  |  | Gender: | Male / Female/ other  |
| NHS No: |  | Ethnicity:  | White - British |
| Nationality: |  | Religion:  |  |
| First Language: | English | Interpreter Needed? Yes / No  |
| Address:  |  |
| Tel: (Home/Mobile)(Parent/Carer) |   | Tel: (Home /Mobile)(Young Person) |  |
| We will send text reminders to the mobile number. Please tick if family does **not** wish to receive these [ ]  |
| Has the child been referred to CAMHS Disability/First Steps/ Specialist CAMHS in the past? Please circle as appropriate Yes [ ]  No [ ]  Don’t Know [ ] Has a sibling been referred to CAMHS Disability/First Steps/ Specialist CAMHS in the past? Please circle as appropriate Yes [ ]  No [ ]  Don’t Know [ ] Sibling name: |
| **Name of person(s) with parental responsibility\*:**  |
| Main Carer(s): Mother [ ]  Father [ ]  Grandparent [ ]  Step Parent [ ]   Guardian/Other [ ]  Foster Parent [ ]  Resident Key Worker [ ]  |
| Name of family members/household | D.O.B age | Relationship to the above | Address if different | School/College or Occupation |
|  |  |   |  |  |
| **Any access needs due to Disability or Health? Yes [ ]  No** **[ ]**  **Please Specify:**  |
| What is the level of learning disability? (if applicable) |  |
| Are there any developmental or medical factors? |  |
| Any physical factors? |
| *If Yes*- What has been tried to date, and what has been helpful? |  |
| **GP DETAILS:** |
| Name:  |  |
| Address (including postcode):Tel: |  |
| **SCHOOL DETAILS:** |
| Name: |  |
| Address (including postcode):Tel: |  |
| Extra support in education/setting? Yes/noEHCP? Yes/**no** | Please comment:  |
| **CONSENT:** |
| Has the parent/carer asked for the referral to be made? Yes/noHas the parent/Carer given informed consent for this referral to be made? Yes/no |
| REFERRED BY: |
| Name: |  | Designation: |  |
| **REASON FOR REFERRAL:**  |
| What is the nature and background of the problem, including how long the difficulties have been occurring; how this is impacting on day to day functioning; other significant concerns and health problems that have affected the child/young person/family; any identified risks; previous interventions and your own view of the problem? How can C AMHS help? |
|   |
| How does the young person/family view this referral? In our experience the success of our work largely depends on the active participation of young people/parents/carers. What in your view is the young person/family’s motivation and ability to engage? Please mention any particular strengths and family resources. |
|  What would you like us to do if we cannot get hold of this person/family? |
| **SAFEGUARDING ISSUES OR ANY RELEVANT HISTORY OF TREATMENT INFORMATION*****Urgent Safeguarding concerns should be directed to children social care:*** 020 8356 5500 |
| Please tick if any member of the family the subject of:Children’s Safeguarding Plan **[ ]**  Any kind of legal restriction order/s [ ]  Court cases either pending or current [ ]  If so, please give details: **Other Agencies (if known):**Social Services [ ]  MAT [ ]  SENCO [ ]  Speech Therapist [ ]  Young Hackney [ ]  LEAP [ ] Occupational Therapist [ ]  Educational Psychologist [ ]  Other [ ]  Adult Mental Health Services **[ ]** Please specify name/contact details of all other professionals involved:  |
| Signed: |  | Date of referral |  |
| Name and designation |  |

Please discuss the reasons you give for the referral with the parents or carers and (allowing for age and ability) the young person concerned. It is helpful to have as much information as possible completed. Could you also enclose the most recent assessments of the child or young person.

\*\*THE ADDITIONAL INFORMATION ON THE FINAL PAGE SHOULD BE COMPLETED ONLY FOR REFERRALS WHERE THERE IS CONCERN ABOUT AN EATING DISORDE

**Eating Disorder Referral**

*The following information is required for referrals to the CAMHS Specialist Eating Disorders Service for Young People.*

*We require information about weight, height, and eating disordered behaviours to determine whether the young person meets our service criteria. Please find out this information before making a referral.*

|  |
| --- |
| **Physical Health** |
| Current weight: | Height: | Weight for height \_\_\_\_\_% |
| Has there been rapid weight loss (more than 500g/week for 2 consecutive weeks) | Yes/No |
| Has there been recurrent fainting? | Yes/No |
| **History** |
| Is the Child or Young Person:  |

|  |  |
| --- | --- |
| Deliberately attempting to lose weight? (e.g. vomiting, dietary restriction, purging or excessive exercise) | **Yes/No**  |
| Bingeing? (a large amount of food in a short time with a feeling of loss of control) | **Yes/No** |

|  |
| --- |
| Please explain how long have these problems been present and what was the weight before the problem started: |
| **Examinations and Investigations**

|  |
| --- |
| ***For healthcare referrers*** |
| Pulse: | BP (lying): | BP (standing): |
| I have sent the young person for the following investigations: |
|  | Yes | No | Result, if known |
| U&E’s |  |  |  |
| TFT’s |  |  |  |
| FBC |  |  |  |
| ESR |  |  |  |
| LFT’s |  |  |  |
| Calcium |  |  |  |
| Phosphate |  |  |  |
| Magnesium  |  |  |  |
| Glucose |  |  |  |
| ***For non-healthcare referrers*** |
| I have directed the young person to their GP for a physical health check? | Yes/No |

 |