### City and Hackney Single Point of Access (SPA) for CAMHS

### Child and Adolescent Mental Health Services Referral Form

If you have any queries before making a referral or wish to discuss a recent referral, please call **020 7014 7079** or email **huh-tr.camhs-spa@nhs.net**

**Please note: If the referral is for a query eating disorder, please ensure that all relevant details are completed by a Health Care Professional on the table at the end of this form. Referrals which do not have minimum required information will be returned to the GP/Referrer for completion before being triaged.**

|  |
| --- |
| INFORMATION about Referred Person: |
| Surname: |  | Forenames: |  |
| Date of Birth:(DD/MM/YYYY) |  | NHS No:*(If known)* |  |
| Ethnicity: |  | Nationality:Religion: |  |
| Sex at birth: | *Or specify:*  | Gender Identity:Pronouns: |  |
| First Language: | Main spoken language  | Interpreter needed? |  |  |
| Address: |   | Postcode: |  |
| **MANDATORY Contact details:** ***Please supply details for both young person and parent/carer*** | **MANDATORY These contact details belong to:** |
| Home Telephone:  |  |  |
| Mobile Telephone:  |  |  |
| Work Telephone:  |  |  |
| E-mail: |   |  |
| Other Contact Details: |  |  |
| Is the YP/family happy to be sent communications about appointments and assessments via email?Is the YP/family happy to be sent text reminders to the mobile phone number? Please select the family’s preferred way(s) of communication:  |
|  |  |  | Other:  |
| Has the child been referred to CAMHS Disability/First Steps/ Specialist CAMHS/ Hackney CFS in the past? *Please tick as appropriate:*   Has a sibling been referred to CAMHS Disability/First Steps/ Specialist CAMHS/Hackney CFS in the past? *Please tick as appropriate:*   Sibling name:  |
| **Name of person(s) with parental responsibility:**  |
| **Main Carer(s):**  |   |  |  |  |
|  |  |  |  |
| Name | D.O.B age | Relationship to the above | Address if different | School/College or Occupation |
|  |  |   |  |  |
| **Any access needs due to Disability or Health?**  |  |
| ***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: *(Please note: We can only accept referrals from CYP under Hackney or City of London GP’s)*** |
| Name:  |  |
| Address (including postcode):Tel: |  |
| **SCHOOL DETAILS:** |
| Name: |  |
| Address (including postcode):Tel: |  |
| Extra learning support in education/setting:  |  |
| EHCP?  |  |
| Please comment if child is not meeting (behind) expected education levels/share details of EHCP if relevant:  |
| **CONSENT:** |
| Has the parent/carer asked for the referral to be made?  |  |  |
| Has the parent/carer given informed consent for this referral to be made?  |  |  |
| If the referral is regarding a query for an ADHD or Autism assessment is the parent/carer aware we will need to contact school to complete the relevant forms?  |  |  |
| **REASON FOR REFERRAL:**  |
| ***Please state reason for your referral,*** describing in as much detail as possible 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
* any identified risks
* any previous interventions
* any other significant concerns or health problems that have affected the child/family.

**What is your own view of the problem and how can CAMHS help?*****Relevant selected consultations:*****Please add here:**  |
| In our experience the success of our work largely depends on the active participation of young people/parents/carers. How does the young person/family view this referral? What in your view is the young person/family’s motivation and ability to engage? Please mention any particular strengths and family resources. |
|   |
| **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 is the subject of:** |
|  |  |
|  |  |
| If so, please give details: |
| **Other Agencies (if known):** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |
| **Name and designation** postal address, and designation: |  | Contact Details:(Telephone & Email) |  |
| **Referral Date:** |  |

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. You can also enclose the most recent assessments of the child or young person.

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

|  |
| --- |
| **Eating Disorder Referral** |
| *The following information is required for referrals to CAMHS Community Eating Disorder Service (CEDS).****Referrals for eating Disorders can be sent directly to the team @*** ***elt-tr.elceds-cyp@nhs.net****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. Some information might need completing by a Healthcare professional, we advise non-healthcare professionals to direct the young person and family to their GP when making a referral to CEDS.**Information marked with a (\*) is necessary in order to process the referral, please ensure those are filled as referrals will be returned if that information is not included.* |
| **Physical Health** |
| **\*** Current weight:  | **\*** Height: No events found.  | Weight for height No events found. % |
| \* Has there been rapid weight loss (more than 500g/week for 2 consecutive weeks) |  |
| \* Has there been recurrent fainting or dizziness?*If yes, please indicate when/how often:* |  |
| Does the young person have any medical condition (including diabetes) or take any prescribed medication? | *If yes, please detail here:*  |
| **History** |
| **Is the Child or Young Person**:  |

|  |  |
| --- | --- |
| \* Deliberately attempting to lose weight?  |  |
| If yes, please indicate which compensatory behaviour is the young person using (e.g., vomiting, dietary restriction, purging or excessive exercise) |  |
| \* Bingeing? (Eating a large amount of food in a short time with a feeling of loss of control) |  |
| \* Concerned about their weight and/or shape? If so, do they have a goal weight in mind?  | Goal weight: |

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

|  |
| --- |
| ***For healthcare referrers:*** |
| Pulse: 23-Apr-2018 **O/E - pulse rate**: 88 beats/min  | 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: |  |

 |