**Newham Child and Adolescent Mental Health Service (CAMHS)**

**Referral Form**

Before completing the form, you **must** discuss the reasons for the referral with the young person and/or parent/ carer (depending on age/ capacity of young person). Please include as much information as possible.

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| **CONSENT** |
| Has the Child / Young Person agreed to this referral? | Yes [x]  No [x]  |
| Has / have the Parent / Carer agreed to this referral? | Yes [x]  No [x]  |

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| REFERRER DETAILS |
| Name |       | Designation |       |
| Organistion |  |
| Address |       | Tel |       |
| Email |       | Date |       |

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| REFERRED CHILD / YOUNG PERSON |
| Forenames |       | Surname |       |
| Date of Birth |       | Gender |       |
| NHS No |       | Ethnicity |       |
| First Language |       | Interpreter needed? |  Yes [x]  No [x]   |
| Address |       |
| Tel (Parent/Carer) |       | Tel (Young Person) |       |

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| **FAMILY MEMBERS** |
| Name(s) of Parent(s)/Carer(s) |  |
| Person(s) with PR and/or Placing Authority (if LAC) |  |
| Main Carer(s) | Mother [x]  Father [x]  Grandparent [x]  Step Parent [x]  Foster Parent [x]  Local Authority [x]  Guardian/Other[x]  Key Worker [x]  |
| **Name of family members** | **D.O.B age** | **Relationship to the above** | **Address (if different)** |
|       |       |       |       |
|       |       |       |       |
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| **SCHOOL** |
| Name |       |
| Address |       |
| Tel |       | Consent to contact School?(Consent assumed unless marked No) | Yes [x]  No [x]  |
| Extra support in education?  |       |

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| **GENERAL PRACTITIONER** |
| Name |       |
| Address |       |
| Tel |       |

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| **REASON FOR REFERRAL** |
| **Symptoms** suggestive of emotional and/or behavioural difficulties: |
|       |
| **Duration** of symptoms:  |
| When did these difficulties first **start**? Have they been consistently present or stopped and started?       |
| **Severity** of symptoms and **impact** on school, family and friends: |
| What impact do the difficulties have on the **family**? What impact do the difficulties have on the young persons’s **social network**?What impact does the difficulties have on the young persons’s **education**?       |
| **Family background** and any **significant events**, changes and illness that may be contributing to difficulties? |
| Is there a **history of mental health** difficulties in the family? Has there been any **stressful events or changes** in the family recently e.g. deaths, separations, house moves, illness? How does the young person **get along** with their family?       |
| **What has been offered**, recommended or tried so far? What has been the impact? |
| Has the young person been offered support or counselling in **school**? Has the young person accessed online counselling e.g. **KOOTH**? Have the parents attended a **Triple P course** (if appropriate)? Has a consulation taken place with an **embedded CAMHS clinician**?      |
| Are there any **risks** to the young person or others? |
| Has the young person **self harmed** recently? If so how?Do they have thoughts or plans to **end their life**? Are there **safeguarding** concerns?       |
| How likely are the young person/family to find **psychological/talking based approaches helpful** in addressing their difficulties? |
| Does the young person/family know **what kind of support** they would like? Have they tried **talking therapy** before? Was it helpful?       |
| What **continued involvement** will you have with the young person/family? |
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| **MULTIAGENCY INVOLVEMENT** |
| If any member of the family is known to **Children’s Social Care, YOT**, other local authority services or other agencies including **physical health or adult mental health services**, please provide further details: (Please specify level of involvement where known) |
|       |
| Is this child or sibling subject to a **Safeguarding Plan**? If so, please give details(Please attach Plan if possible) |
|       |

FOR EATING DISORDERS, ADDITIONAL INFORMATION REQUESTED OVERLEAF

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| **EATING DISORDER REFERRALS ONLY** |

THIS ADDITIONAL INFORMATION IS **ONLY** REQUIRED WHERE THERE IS CONCERN ABOUT AN EATING DISORDER

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| **HISTORY** |
|  Is the Child /Young Person deliberately attempting to lose weight or not managing to gain weight? | Yes [x]  No [x]  |
| Has there been rapid weight loss ?(more than 500g / week for 2 consecutive weeks) | Yes [x]  No [x]  |
| Is the young person bingeing/purging? | Yes [x]  No [x]  |
| **PHYSICAL** |
| Current weight:  | Height:  |  |
| Are there any physical health concerns e.g. dizziness, fainting?  |  |
| **INVESTIGATIONS** |
| ***For healthcare referrers:*** |
| Have any physical investigations been requested?  | Yes [x]  No [x]  |
| Please give details:       |
| ***For non healthcare referrers:*** |
| Have you directed the young person to their GP for a physical health check? | Yes [x]  No [x]  |

PLEASE RETURN ALL REFERRAL FORMS TO:

**Newham Child & Adolescent Mental Health Service**

**elft.enquiries-newhamcfcs@nhs.net**

**Tel: 020 8430 9000**

**Postal address: York House, 411 Barking Road, Plaistow, London E13 8AL**

***For any queries or if you would like to talk to a clinician about your referral please call the number above.***