**Child and Adolescent Mental Health Services (CAMHS)**

**Referral Form (Bedfordshire)**

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Before completing the form, you **must** discuss the reasons you give for the referral with young person and/or parent/ carer (depending on 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 No |
| Has the Child / Young Person consented to parent/carer involvement for this referral? | Yes No |
| Has / have the Parent(s) / Carer(s) agreed to this referral? | Yes No  Not consulted |

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| --- | --- | --- | --- |
| REFERRED CHILD / YOUNG PERSON | | | |
| Surname |  | Forenames |  |
| Alias: |  | Date of Birth |  |
| Gender | Male inc. Trans Male  Female inc. Trans Female  Non Binary  Gender Fluid  Self Describe:\_\_\_\_\_\_\_ UnknownDo not Wish to Share | Sexual Orientation | Heterosexual/Straight  Gay/Lesbian  Bisexual  Self Describe: \_\_\_\_\_\_  Unknown  Do not Wish to Share |
| Does your Gender Align with your sex assigned? | Yes/ No | Pronouns | She/Her  He/Him  They/Them  Self Describe:\_\_\_\_\_\_\_  Do not Wish to Share |
| **COMMUNICATION WITH YOUNG PERSON**  Is there any information you or the young person would like us to know regarding how best to communicate with them?  Examples of helpful information include the use of the young person’s gender identity, pronouns, name, sexual orientation, or how best to contact the young person, their family or school to maintain confidentiality | | | |
|  | | | |
| NHS No |  | Ethnicity |  |
| First Language |  | Interpreter needed? | Child: Yes No  Family/Carers: Yes No |
| 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  Father  Grandparent  Step Parent  Foster Parent  Local Authority  Guardian/Other  Key Worker | |
| **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) | | Yes No |
| Extra support in education? |  | | What Level (if known) |  | |
| **GENERAL PRACTITIONER** | | | | | |
| Name |  | | | | |
| Address |  | | | | |
| Tel |  | Consent to contact GP?  (Consent assumed unless marked) | | | Yes No |

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| **REASON FOR REFERRAL** |
| **Presenting Problem**  Describe the problem; Severity; Duration; Impact; Other significant concerns; Health problems; Identified risks; Previous interventions; previous CAMHS involvement & outcome |
|  |
| What continued involvement will you have with the family? |
|  |
| Any additional information: |
|  |

Referred Child’s Name: D.o.b:

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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) |
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| Is this child or sibling subject to a Safeguarding Plan? If so, please give details  (Please attach Plan if possible) |
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| REFERRER | | | | | |
| Name | Completed via T/C with duty | Designation |  | | |
| Team Name/Organisation |  | | | | |
| Address |  | | | Tel |  |
| Signature |  | | | Date |  |

FOR EATING DISORDERS, ADDITIONAL INFORMATION REQUESTED OVERLEAF

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| **EATING DISORDER REFERRALS** |

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

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| **HISTORY** |

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| --- | --- | --- | --- | --- |
| Is the Child /Young Person deliberately attempting to lose weight or not managing to gain weight? | | | | Yes No |
| Has there been rapid weight loss ?  (more than 500g / week for 2 consecutive weeks) | | | | Yes No |
| Is the young person bingeing/purging? | | | | Yes No |
| **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 No |
| Please give details: | | | | |
| ***For non healthcare referrers:*** | | | | |
| Have you directed the young person to their GP for a physical health check? | | | | Yes No |

PLEASE RETURN ALL REFERRAL FORMS TO:

[**elft.spoebedfordshire@nhs.net**](mailto:elft.spoebedfordshire@nhs.net)

Bedfordshire CAMHS, 9 Rush Court, Bedfordshire. MK40 3JT

**Telephone:** 01234 893304 / 01234 893300 / 01234 893301

***For any queries or if you would like to talk to the duty clinician about your referral please call the number above and they will redirect you to the duty clinician for your catchment.***