**Referral Form**

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

|  |
| --- |
| **CONSENT** |
| Has the Child / Young Person agreed to this referral? | Yes [ ]  No [ ]  |
| Has / have the Parent(s) / Carer(s) agreed to this referral? | Yes [ ]  No [ ]  |
| All referrals into CAMHS are treated with assumed consent for onward referral to appropriate non-NHS community partners who support young peoples wellbeing. Please indicate interests in **Additional Support Section** | Yes ☐ No ☐ |

|  |
| --- |
| REFERRER DETAILS |
| Name | Completed via T/C with duty | Designation |  |
| Organisation |  |
| Address |  | Tel |  |
| Email |  | Date |  |

|  |
| --- |
| REFERRED CHILD / YOUNG PERSON |
| Forenames |  | Surname |  |
| Date of Birth |  | Gender |  |
| Pronouns | She/Her [ ]  He/Him [ ]  | They/Them [ ]  Self Describe  | Do Not wish to Share [ ]  |
| NHS No |  | Ethnicity |  |
| First Language |  | Interpreter needed? |  Yes [ ]  No [ ]   |
| Address |  |
| Tel (Parent/Carer) |  | Tel (Young Person) |  |

|  |
| --- |
| **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)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **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 |  |

|  |
| --- |
| **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, KOOTH?Have the parents attended a Triple P course (if appropriate)? |
| Are there any risks to the young person or others? |
| Has the yp self harmed recently? If so how?Do they have thoughts or plans to end their life?Are there safeguarding concerns? |
| Will the young person and or family engage in psychological/talking approaches to address their difficulties? |
| Does the family young person 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 family? |
|  |

|  |
| --- |
| **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) |
|  |

|  |
| --- |
| **ADDITIONAL COMMUNITY SUPPORT** |
| Please discuss the following options with the young person and indicate what types of support the young person would be open to engaging with. *(\*age limits in brackets*) |
| Mentoring (12+) [ ]  | Basketball (14+) [ ]  | Boxing (7+) [ ]  | Art (11+) [ ]  | Dance (4+) [ ]  |
| Music production (11+)[ ]  | Youth Zones (12+) [ ]  | Young carers support [ ]  | Videogame therapy (7-12) [ ]  | Outdoor activity [ ]  |
| **EATING DISORDER REFERRALS** |

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

|  |
| --- |
| **HISTORY** |

|  |  |
| --- | --- |
|  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:

**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.***