**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  No |
| Has / have the Parent / Carer agreed to this referral? | Yes  No |

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

|  |  |  |  |
| --- | --- | --- | --- |
| REFERRED CHILD / YOUNG PERSON | | | |
| Forenames |  | Surname |  |
| Date of Birth |  | Gender |  |
| NHS No |  | Ethnicity |  |
| First Language |  | Interpreter needed? | 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 No) | Yes  No |
| Extra support in education? |  | | |

|  |  |
| --- | --- |
| **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) |
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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  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**](mailto: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.***