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

**Referral Form (Luton)**

###

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.

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| REFERRED CHILD / YOUNG PERSON |
| Surname |  | Forenames |  |
| Date of Birth |  | Gender |  |
| NHS No |  | Ethnicity |  |
| First Language: |  | Interpreter needed? |   |
| 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 |
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| What continued involvement will you have with the family? |
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| 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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| **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 |

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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? |   |
| **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:

Email: elft.luton-southcamhs-spoe@nhs.net

**Luton CAMHS**

 Luton CAMHS,Floor 1, Charter House, Alma Street, Luton , LU1 2PJ

 **Telephone:** 01525 638613 **or** 01525 638614 **Fax:** 01582 709081

***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.***