**Multi-agency referral form for Specialist CAMHS referral & consultation.**

Please e-mail completed form securely to Single Point of Access at:-

tewv.camhsspayorkselby@nhs.net

Or contact the service to discuss referral on:- **01904 - 615345**

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| Date of referral: – Date received in service: - |

**Child/Young Person & Family Details:-**

|  |  |  |
| --- | --- | --- |
| **Full Name of Child:**  |  | **Date of Birth:** |
| **Preferred Name:**  |  | **Age** |
| **Male/Female:** |  |  |
| **Address including postcode:** | **Preferred agreed Primary contact and Daytime Telephone number:** [ ]  **Parent/Carer** **Name:****OR**[ ]  **Young Person (where appropriate)**  |
| **Agreed Secondary Contact and Telephone number (to be used if problems with number above):**[ ]  **Parent /Carer**  **Name:****OR**[ ]  **Young Person’s (where appropriate)**  |
| **Has consent for referral been given? YES** [ ]  **NO** [ ] **:** **By whom (name):** | **Parent/Carer aware of referral**  | **YES** [ ]  **NO** [ ]  |
| **GP Name & Address:****Postcode:** **GP Phone No:** | **NHS No:**  |
| **Nationality:** | **Religion:** | **Ethnicity:** |
| **Marital Status:** |  |  |

**Parent/Carer/Sibling Details (if relevant):-**

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| **Parent / Carer Name (s) and DOB: (including title, surname and relationship to child/YP)****Who has Parental Responsibility?(name/s)** |
| **Who does the child / Young Person live with? (name, DOB & relationship to child/YP)** |
| **Siblings living in the family home (Name, DOB & School):**  |

**Details about the difficulty/issue:-**

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| **What is the reason for the referral?** |
| **How long has the issue been going on?** |
| **How often is it happening & how is it impacting?** |
| **What is it like in different settings e.g. school, activity groups, public places?** |
| **Risk**Historical risk factors. Current risk factors, vulnerabilities (balanced with protective / resilience factors – what has worked or not worked, what is going well.Change in mood – what are they and when did they start, poor or increased sleep, poor concentration or indecisiveness, Low self confidencePoor or increased appetiteSuicidal thoughts/ self-harmAggressive behaviour towards others  |
| **Resilience** **Protective factors (e.g. friendships, good family relationship’s)**, **what has / has not worked (e.g. taking time out when feels anxiety rising, school supporting workload, what is going well** |
| **What do you and the young person/carer hope the service can provide?**  |
| **Have other services been involved to meet the needs of the child, young person or family?** i.e.: Healthy Child Programme, COMPASS Reach, Local Authority Prevention Service or Voluntary Sector Services, Education Services.  |

**Additional Information:-**

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| --- | --- |
| **Health issues, significant past medical history, previous CAMHS involvement.**  |  |
| **Medication:** |  |
| **Allergies:** |  |
| **Language Difficulties child/parent (Please specify - to assist with telephone assessment).****Interpreter Required:** | **YES** [ ]  **NO** [ ] **:**  |
| **School/College attended (Please include telephone number where possible)** |  |
| **Education Health and Care Plan in place?**  | **YES** [ ]  **NO** [ ]  **Don’t know** [ ]  |
| **Learning Disability/Difficulties known?** | **YES** [ ]  **NO** [ ] **:**  |
| **Child Protection Plan in place?** | **YES** [ ]  **NO** [ ] **:**  |
| **Child in Need Plan/CAF in place?** | **YES** [ ]  **NO** [ ] **:**  |

**Other professionals involved in care of child/ young person:- (please complete where this information is known.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes / No** | **Name if Known** | **Consent to contact Yes/No** | **Contact number** |
| **General Practitioner** |  |  |  |  |
| **Children Social Care** |  |  |  |  |
| **Support in Education** |  |  |  |  |
| **Emotional Wellbeing Worker** |  |  |  |  |
| **Prevention Service/Family Outreach Worker** |  |  |  |  |
| **Healthy Child Practitioner** |  |  |  |  |
| **Voluntary Services** |  |  |  |  |
| **Youth Justice Service** |  |  |  |  |
| **Other** |  |  |  |  |

**Referral Source:-**

|  |  |
| --- | --- |
| **Referral from Professional/Agency:-****Status of referral request**  | **Name:****Address:****Tel. number:****Routine YES** [ ] **Urgent YES** [ ]  |

**LOCAL AUTHORITY REQUESTS FOR Consultation/Assessment:-**

**This section must be completed fully for request to proceed**

|  |  |
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| **Name of Social Worker** | **Consultation request** [ ]  **: Assessment request** [ ] **:**  |
| **Name of Social Worker Manager****Agreement to proceed to CAMHS?** | **YES** [ ]  **NO** [ ] **:**  |
| **Strengths & Difficulties Questionnaire attached** | **YES** [ ]  **NO** [ ] **:**  |