Referral Form

Mental Health Support Team

Please complete all areas of the referral form and email the complete form to:
CAMHSGettingHelpEastReferrals@berkshire.nhs.uk

If the young person requires urgent support, please use the contact details listed at the bottom of this referral form.

Child/young person's first name:		**DOB:**
Child/young person's surname:		**Gender:**
NHS Number		
Ethnicity		
Spoken language		
Is an interpreter needed? (for Parent/Carer or child or young person)		
Parent/carer's names *Include forename(s) and surnames and please include all who hold parental responsibility where appropriate*		
Home placement contact details	***Home telephone:***	
	Mobile:	
	Address:	
	Email Address:	
Present school/college/course details *(name)*		**Year group**
Head of year and form tutor names *(if possible)*		

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Referrer Details	***Name***			
	Email			
	Telephone			
Date of Referral *(dd/mm/yyyy)*				
CLA *(Child looked after)*				
Details of social worker involved if applicable: (*Name and contact details*)				
Is the child/young person aware of the referral? *Please tick yes or no*	***Yes***	☐	***No***	☐
Has this referral been discussed in consultation?	***Yes***	☐	***No***	☐
Is the child a young carer? *Please tick yes or no*	***Yes***	☐	***No***	☐
Medication Details ***(e.g. name, dose, duration, side effects, prescriber)***				
Details of any professional reports attached				

Please tick all that are appropriate	***Child in care***	☐
	Child protection	☐
	Child in need	☐
	Early help family assessment	☐
	Adopted (if parents happy to share)	☐
	SEND	☐
	Pupil premium	☐
	Gillick Competency	☐

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What has been actioned already? ***Please tick all that apply***	**Spoken to young person**	☐
	Contacted parents/carers	☐
	Information shared about MHST	☐
	GP involvement with referral	☐
What interventions/support have already been delivered? ***Please tick all that apply***	**None**	☐
	Group/workshop	☐
	1:1/counselling	☐
	Nurture Group	☐
	ELSA support	☐
	Pastoral support	☐
	School nurse	☐
	Other	☐
If you have ticked any of the above, please provide details ***e.g. dates, number of sessions and any other relevant information***		
If you have ticked 'other', please specify and give details here		

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Brief Summary of Referral

What is the main presenting problem?

- mild to moderate anxiety (e.g. separation anxiety, general worries, specific phobia, panic attacks)

- low mood

- and/or behavioural difficulties.

What does this look like?

If known, please specify specific worrying/low mood thoughts, physical symptoms, emotions and behaviours the young person experiences and displays.

How does the problem impact the child, young person and/or their family?

Please provide examples where possible.

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Previous MH history

Diagnosis or pending assessment *(please specify)*	**CAMHS/EP/clinician involvement *(Yes/No)***	**Details of involvement *e.g. who, when, why***

What have you done already?

What's not working so well? (E.g. self harm / suicidal thoughts / aggression or hostility/ neglect / bullied or bullying / alcohol or drug use)

Current coping strategies (if known)

Support network (family, friends, other significant people, external agencies involved)

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Desired outcomes (goals)

What does the child/young person want help with?

What would the child/young person like to be different if they weren't feeling this way?

What does the child/young person hope to achieve from support from MHST?

What does their family hope to achieve from support from MHST?

Consent to share:

Yes ☐ **No** ☐

Parent/Carer Signature: …… Date: ……

Young person's Signature: …… Date: ……

Referrer's Signature: …… Date: ……

Requesters role/designation:

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Date For EMHPS use only	Appendix 1 (pre-measure)		Appendix 2 (post-measure)	
	Date completed:		Date completed:	
	Baseline:		Review:	

CRISIS CONTACT		
East CAMHS	Monday to Friday (excluding Bank Holidays) 9am - 5pm	0300 365 0123 option 1
CAMHS Out of Hours	Monday to Friday 5pm-8pm Monday to Friday 8pm – 9am & all weekend	0300 365 1234 0300 365 9999
NHS Direct	24 hours	111
ChildLine	24 hours	0800 1111
Samaritans	24 hours	116 123
Mental Health, medical emergency or safety concerns	24 hours	999