**Referral Form**

**Mental Health Support Team**

**Please complete all areas of the referral form and email the complete form to:**

[**CAMHSGettingHelpEastReferrals@berkshire.nhs.uk**](mailto: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)*** | | | | | | | |
|  |  | | | | | | |
| **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** | | |  | | |
| **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. |
| **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)**  **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:**

**……………………………………………………………………...**

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