**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.**

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| **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*** |
|  |  |  |
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|  |  |  |

**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:** |  |

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| **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-8pmMonday to Friday 8pm – 9am& all weekend | 0300 365 12340300 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 |