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

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| **Ealing MHST referral form for use from May 2020** |

**Please email this completed form to** **ealing.mhst@nhs.net** **ensuring it is sent securely (e.g. via Egress) and in line with your information governance policies.**

*We are required to register the full* ***demographic details*** *of all referrals. We also require that all questions concerning* ***consent*** *are answered. Please include this information in your referral to avoid our having to return this form to you prior to triage.*

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| **Date of Referral** |  |
| **Purpose of referral** | [ ]  Wellbeing practitioner referral [ ]  ASC-LD practitioner referral |

| **Child/Young Person (Patient) Details** | **Parent/Carer/Guardian Details** |
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| **First Name** |  | **Name of Parent 1** |  |
| **Surname** |  | **Address** |  |
| **NHS No** |  | **Home or Mobile Tel** |  |
| **DOB** |  | **Email** |  |
| **Gender** |  | **Name of Parent 2** |  |
| **Ethnicity** |  | **Address** |  |
| **Address** |  | **Home or Mobile Tel** |  |
| **Area of Residency** |  | **Email** |  |
| **Home Tel** |  | **Name of Carer/ Guardian** *if applicable* |  |
| **Mobile Tel** |  | **Address** *if applicable* |  |
| **Email** |  | **Home or Mobile Tel** *if applicable* |  |
| **Email** *if applicable* |  |
| **Marital Status** | [ ] Single [ ] Other [ ] Not Specified | **Main residence of child/young person** |  |
| **Main Language spoken** |  | **Main language spoken by family** |  |
| **Learning Disability** | [ ] No [ ] Yes | **Learning Disability** | [ ] No [ ] Yes - |
| **Physical Disability** | [ ] No [ ] Yes | **Physical Disability** | [ ] No [ ] Yes |
| **Interpreter** | [ ] No [ ] Yes  | **Interpreter** | [ ] No [ ] Yes  |
| **GP Name if not referrer** |  | **Who holds parental responsibility?****(**give details e.g. parent/carer/Local Authority (LAC) include name and contact details if not already shown above) |  |
| **GP Phone No** |  |
| **GP Address if not referrer** |  |
| **GP admin email address *if known*** |  |
| **School/College***if applicable* |  |
| **School/College****Address** |  |
| **School/College Phone No** |  |

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| **Referrer Details** |
| **Name** |  | **Telephone No** |  |
| **Role/Title** |  | **Email address (NHS or egress)** |  |
| **Organisation** |  |

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| **Consent – if this section is not completed fully, the referral will be returned to you prior to triage** |
| Has the child/young person/family had previous involvement with this or any other CAMHS | [ ] Yes | [ ] No |
| Do the parents/carer/guardians (who have parental responsibility) consent to this referral to CAMHS | [ ] Yes | [ ] No |
| Do the parents/carer/guardians (who have parental responsibility) consent to this referral to CAMHS being shared with another more appropriate NHS or Local Authority Service? This includes being sent to another Trust such as CNWL. | [ ] Yes | [ ] No |
| If no, are the parents/carer/guardians (who have parental responsibility) aware of this referral? | [ ] Yes | [ ] No |
| **If the young person is 16 years and over**, does the young person consent to this referral to CAMHS | [ ] Yes | [ ] NA |
| **If the young person is 16 years and over**, does the young person consent to this referral to CAMHS being shared with another more appropriate NHS or Local Authority Service? This includes being sent to another Trust such as CNWL. | [ ] Yes | [ ] NA |
| **If the young person is 16 years and over**, does the young person consent to this referral being shared with their parents/carer/guardians? | [ ] Yes | [ ] NA |
| Are there any other matters such as culture, language, illness, religion or disability that we may need to consider when getting in touch. If you have indicated that there is a learning or physical disability affecting the Child/Young Person or family member, please specify here: | [ ] YesGive Details: | [ ] No |
| **Reason for Referral** |
| **Reason for Referral***(Please specify why you think a CAMHS assessment is required and what you wish the service to do)* |  |
| **Main Concerns – Symptoms** *(Give details about onset, duration, frequency, severity)* |  |
| **Settings (Home, School and Community)***(Neurodevelopmental disorders and other mental health conditions are pervasive across settings – home, school and community. Give details in relation to different settings)* |  |
| **Impact, Distress and Impairment***(Give details of child development, family life, social life, learning/academic performance)* |  |
| **Risk /Safeguarding Concerns** |  |
| Is the family known to Children’s Social Services? | [ ] No [ ] Yes [ ] UnsureIf yes give details: |
| Does the child have an Education, Health & Care Plan (EHCP), Child Protection (CP) Plan, Child in Need (CIN) Plan? | [ ] EHCP [ ] CP [ ] CIN |
| Is the child/young person a Looked After Child (LAC)  | [ ] No [ ] Yes [ ] Unsure |
| Is the child/young person/family currently involved in Legal Proceedings relating to the child/young person? | [ ] No [ ] Yes [ ] UnsureIf yes give details: |
| Are you aware of any domestic violence or abuse issues in this family? | [ ] No [ ] Yes [ ] UnsureIf yes give details: |
| Are you aware of any drug or alcohol issues in this family? | [ ] No [ ] Yes [ ] UnsureIf yes give details: |
| **Medical History***(If known to the school)* |  |
| **Current Acute Medication in last month***(If known to the school)* |  |
| **Current Repeat Medication***(If known to the school)* |  |
| **Allergies & Sensitivities***(If known to the school)* |  |
| **Interventions Previously Tried (Individual and/or family)***(Give brief details of school, universal/primary/secondary interventions)* |  |
| **Other Professionals Involved** |  |
| **Other Professionals Involved and Reports***(Give details of other agencies involved now or in the past with the child/young person and family)* | **Agency Name** | **Named Worker** | **Address** | **Tel No** |
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| Is the child/young person on a waiting list for a service? | [ ] No [ ] Yes [ ] UnsureIf yes give details: |
| Relevant reports attached | [ ] No [ ] YesIf No, please give reasons as this may significantly delay the processing of this referral:Please state which reports are attached |