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

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| [ ]  **Ealing CAMHS**1 Armstrong WaySouthallMiddlesexUB2 4SATel: 020 8354 8160Email referrals to:**wlm-tr.EalingCamhs@nhs.net** | [ ] **Hammersmith & Fulham CAMHS**48 Glenthorne RoadHammersmithLondonW6 0LSTel: 020 8483 1979Email referral to:**wlm-tr.hfcamhs@nhs.net** | [ ] **Hounslow CAMHS**Heart of Hounslow Centre for Health92 Bath RoadHounslowTW3 3ELTel: 020 8483 2050E-mail referrals to:**hounslow.camhs@nhs.net**CAMHS Consultant helpline for Hounslow patients **ONLY**020 8483 2452Every Tuesday 12 noon to 1pm |

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| **CAMHS Referral form for use from July 2019** |

**Please email this completed form to your local CAMHS Service. Faxes are no longer accepted.**

**We are required to register the full demographic details (including area of residency, GP details and NHS number) of all referrals. Please include this information in your referral otherwise we will need to return this form to you prior to triage.**

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| **Date of referral** | Click or tap here to enter text. |
| **PRIORITY**(see separate guidance) | [ ]  Routine  | [ ]  Urgent |

| **Child/Young Person (Patient) Details** | **Parent/Carer/Guardian Details** |
| --- | --- |
| **First name** | Click or tap here to enter text. | **Mothers name** | Click or tap here to enter text. |
| **Surname** | Click or tap here to enter text. | **Mothers address** | Click or tap here to enter text. |
| **NHS No** | Click or tap here to enter text. | **Mothers home or mobile tel** | Click or tap here to enter text. |
| **DOB** | Click or tap here to enter text. | **Mothers email** | Click or tap here to enter text. |
| **Gender** | Click or tap here to enter text. | **Fathers name** | Click or tap here to enter text. |
| **Ethnicity** | Click or tap here to enter text. | **Fathers address** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. | **Fathers home or mobile tel** | Click or tap here to enter text. |
| **Area of residency** | Click or tap here to enter text. | **Fathers email** | Click or tap here to enter text. |
| **Home Tel** | Click or tap here to enter text. | **Carer/ guardian name** *if applicable* | Click or tap here to enter text. |
| **Mobile Tel** | Click or tap here to enter text. | **Carer/ guardian Address** *if applicable* | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. | **Carer/ guardian home or mobile** *if applicable* | Click or tap here to enter text. |
| **Carer/ guardian email** *if applicable* | Click or tap here to enter text. |

| **Child/Young Person (Patient) Details** | **Parent/Carer/Guardian Details** |
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| **Main Language spoken** | Click or tap here to enter text. | **Main language spoken by family** | Click or tap here to enter text. |
| **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** | Click or tap here to enter text. | **Who holds parental responsibility?****(**give details e.g. parent/carer/Local Authority (LAC) include name and contact details if not already shown above)Click or tap here to enter text. |
| **GP Phone No** | Click or tap here to enter text. |
| **GP Address if not referrer** | Click or tap here to enter text. |
| **GP admin email address *if known*** | Click or tap here to enter text. |
| **School/College***if applicable* | Click or tap here to enter text. |
| **School/College****Address** | Click or tap here to enter text. |
| **School/College Phone No** | Click or tap here to enter text. |
| **Special School** | [ ] No [ ] Yes |

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| **Referrer Details** |
| **Name** | Click or tap here to enter text. | **Organisation code** *if applicable* | Click or tap here to enter text. |
| **Role/title** | Click or tap here to enter text. | **Telephone No** | Click or tap here to enter text. |
| **Organisation** | Click or tap here to enter text. | **Email admin (NHS or egress)** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |

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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.  | [ ]  Yes | [ ]  No |
| If you have indicated that there is a learning or physical disability affecting the Child/Young Person or family member, please specify here:Click or tap here to enter text. |

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| **Reason for referral** |
| **Reason for referral***(Please specify why you think a CAMHS assessment is required and what you wish the service to do)* | Click or tap here to enter text. |
| **Main concerns – Symptoms** *(Give details about onset, duration, frequency, severity)* | Click or tap here to enter text. |
| **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)* | Click or tap here to enter text. |
| **Impact, distress and impairment***(Give details of child development, family life, social life, learning/academic performance)* | Click or tap here to enter text. |
| **Risk /safeguarding concerns** | Click or tap here to enter text. |
| Is the family known to Children’s Social Services? | [ ]  No [ ]  Yes [ ]  UnsureIf yes give details: Click or tap here to enter text. |
| 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: Click or tap here to enter text. |
| 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: Click or tap here to enter text. |
| **Medical history***(Give enough details to rule out organic conditions)* | Click or tap here to enter text. |
| **Current acute medication in last month** | Click or tap here to enter text. |
| **Current repeat medication** | Click or tap here to enter text. |
| **Allergies and sensitivities** | Click or tap here to enter text. |
| **Interventions previously tried (individual and/or family)***(Give details of school, universal/primary/secondary interventions)* | Click or tap here to enter text. |

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| **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 number** |
| Enter agency name. | Enter named worker. | Enter address. | Contact number. |
| Enter agency name. | Enter named worker. | Enter address. | Contact number. |
| Enter agency name. | Enter named worker. | Enter address. | Contact number. |
| Enter agency name. | Enter named worker. | Enter address. | Contact number. |
| Is the child/young person on a waiting list for a service? | [ ]  No [ ]  Yes [ ]  UnsureIf yes give details: Click or tap here to enter text. |
| Relevant reports attached | [ ]  No [ ]  YesIf No, please give reasons as this may significantly delay the processing of this referral:Click or tap here to enter text.Please state which reports are attachedClick or tap here to enter text. |