**Multi-agency referral form for Specialist CAMHS referral.**

|  |  |
| --- | --- |
| **Date of referral:****Referral from:****Status of referral request :** | **Name and service:****Address:****Tel. number:****Routine YES** [ ] **Urgent YES** [ ] **(If you require crisis intervention please contact 0800 0516171)** |

**Child/Young Person details:**

|  |  |
| --- | --- |
| **Full name of Young person:** |  |
| **Preferred name:** |  |
| **NHS Number:** |  |
| **Male/Female:** | **MALE** [ ]  **FEMALE** [ ]  |
| **Date of Birth & Age:** |  |
| **Language Spoken:** |  |
| **Nationality and Religion:** |  |
| **Address including postcode:** |  |
| **Contact telephone number:** | [ ]  **Parent/Carer** **Name:** **OR**[ ]  **Young Person (if over 16)** |
| **School/College/ attended:** |  |

**Consent:**

|  |  |
| --- | --- |
| **Has consent been obtained by the parent?**  | **YES** [ ]  **NO** [ ]  **(if no, why?)** |
| **Has consent been obtained by the young person? If the young person is 16 or over consent MUST be obtained by them before you submit your referral.** | **YES** [ ]  **NO** [ ]  **(if no, why?)** |
| **Has consent been obtained by the parent/ young person to discuss their care with other professionals on a need to know basis?** | **YES** [ ]  **NO** [ ]  |

**Parent/Carer/Sibling Details (if relevant):-**

|  |  |
| --- | --- |
| **Parent / Carer Name and DOB:**  |  |
| **Who has Parental Responsibility?** |  |
| **Who does the child / Young Person live with? (name, DOB & relationship to child/YP)** |  |
| **Siblings under 16yrs living in the family home (Name, DOB & School):**  |  |

**Details about the difficulty/issue:-**

|  |
| --- |
| **What is the reason for the referral and how long has this been going on?** |
| **How often is it happening & how is it impacting on their daily functioning?** |
| **Risk****(suicidal thoughts, intent or plans of suicide, self-harming behavior’s, aggression towards self or others, vulnerable, at risk of harm from others)** |
| **Resilience** **Protective factors (e.g friendships, good family relationship’s)**, **what has / has not worked (e.g. taking time out when feels anxiety rising, school supporting workload, what is going well** |
| **What do you and the young person/carer hope the service can provide?**  |
| **Have other services been involved or are currently involved to meet the needs of the child, young person or family?** **ie: Healthy Child Programme, COMPASS Reach, Local Authority Early help Service or Voluntary Sector Services, Education Services.**  |

**Additional Information:-**

|  |  |
| --- | --- |
| **Health issues, significant past medical history:**  |  |
| **Medication:** |  |
| **Allergies:** |  |
| **Language Difficulties (to assist with telephone assessment).****Interpreter Required:** | **YES** [ ]  **NO** [ ]  |
| **Learning Disability/Difficulties known?** | **YES** [ ]  **NO** [ ]  |
| **Child Protection Plan in place?** | **YES** [ ]  **NO** [ ] **: If yes, please provide name and contact number of SW below)** |
| **Child in Need Plan in place?** | **YES** [ ]  **NO** [ ] **:**  |

**Other professionals involved in care of child/ young person:-**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes / No** | **Name if Known** | **Consent to contact**  | **Contact number** |
| **General Practitioner** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Social Worker** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Support in Education** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Early help Service** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Healthy Child Practitioner** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Voluntary Services** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Youth Justice Service** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **PIPA Service** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Other** |  |  | **YES** [ ]  **NO** [ ]  |  |

Please e-mail completed form securely to Single Point of Access at:-

tewv.northyorkshirecamhsreferrals@nhs.net

**Or contact the service to discuss referral on:- 0300 0134778 (please note we do not accept referrals via telephone by professionals)**

**We accept self-referrals by young people or parents mon-fri between 10-11.30am (expect bank holidays) by calling 0300 0134778.**

***We would also suggest the following useful websites to be given to Families/Young People whilst awaiting a response to the referral:***

* [www.recoverycollegeonline.co.uk](http://www.recoverycollegeonline.co.uk)
* www.kooth.com