**Return completed form to:** Tavistock and Portman FT Col A

**Email:** [portman.fcamhs@nhs.net](mailto:portman.fcamhs@nhs.net)

**The Port (FCAMHS)** Portman Clinic

8 Fitzjohns Avenue, London NW3 5NA **Telephone:** 020 8938 2089

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **The Port (FCAMHS) Referral Form** | | | | | | |
| **Date of Referral:** | Click here to enter a date. | **OFFICE USE ONLY** | | | Date Received: | Click here to enter a date. |
| **Child/Young Person (CYP) Information** | | | **Please complete as fully as possible** | Date Acknowledged: | | Click here to enter a date. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name:** | | Click here to enter text. | | | | | | **Date of Birth:** | | | | Click here to enter a date. | | | **Age at Referral:** | Choose an item. |
| **Gender:** | Click here to enter text. | | | **Ethnicity:** | | Choose an item. | | | | **First Language:** | | | | Click here to enter text. | | |
| **NHS Number:** | | | Click here to enter text. | | **Religion:** | | Click here to enter text. | | | | | | | | | |
| **Home Address:** | |  | | | | | | | **Address at time of referral:** *(if different****)*** | | | | Click here to enter text. | | | |
| **Postcode:** | | Click here to enter text. | | | | | | | **Postcode:** | | Click here to enter text. | | | | | |
| **Tel No(s):** | | Click here to enter text. | | | | | | | **Tel No:** | | Click here to enter text. | | | | | |

|  |  |
| --- | --- |
| **Are you an ex-member of the British armed forces or dependent on such a person?** | No  Yes (ex-services member)  Yes (dependent upon an ex-services member)  Unknown |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GP Name:** | Click here to enter text. | | **GP Tel No:** | Click here to enter text. |
| **GP Practice Address:** | | Click here to enter text. | | |
| **Postcode:** | Click here to enter text. | | | |

|  |  |  |
| --- | --- | --- |
| **Has consent been obtained for this referral to FCAMHS?** | | **If YES, please name the person giving consent:** |
| **YES** | **NO** | Click here to enter text. |
| **Please note, by submitting this referral, you are also confirming that you have followed your local consent policies. This includes gaining the relevant consent for referring to our service, and the sharing of appropriate information across agencies involved.** | | |

**Next of Kin/Carer/Person with Parental Responsibility Information**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | Click here to enter text. | | | | | **Name:** | Click here to enter text. | | | | |
| **Address:** | | Click here to enter text. | | | | **Address:** | | Click here to enter text. | | | |
| **Postcode:** | | Click here to enter text. | | | | **Postcode:** | | Click here to enter text. | | | |
| **Relationship to CYP:** | | | Click here to enter text. | | | **Relationship to CYP:** | | | Click here to enter text. | | |
| **Aware of FCAMHS referral?** | | | | **YES** | **NO** | **Aware of FCAMHS referral?** | | | | **YES** | **NO** |

**Referrer Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | Click here to enter text. | | | | | | | **Tel No(s):** | | Click here to enter text. | | | |
| **Title/Professional Designation:** | | | | | Click here to enter text. | | | | | | | | |
| **Address:** | | Click here to enter text. | | | | | | | | | | | |
| **Postcode:** | | Click here to enter text. | | | | **Email:** | Click here to enter text. | | | | | | |
| **Alternative Contact:** | | | Click here to enter text. | | | | | | **Email:** | | Click here to enter text. | | |
| **Title/Professional Designation:** | | | | | Click here to enter text. | | | | | | | | |
| **Capacity** (eg. Co-worker/Manager)**:** | | | | Click here to enter text. | | | | | | | | **Tel No:** | Click here to enter text. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Is the named Referrer the Lead/Coordinating Professional?**  If **NO**, please give details below | | | | | | **YES** | **NO** |
| **Name:** | Click here to enter text. | | | **Tel No:** | Click here to enter text. | | |
| **Professional Designation:** | | Click here to enter text. | | | | | |
| **Address:** | Click here to enter text. | | | | | | |
| **Postcode:** | Click here to enter text. | | **Email:** | Click here to enter text. | | | |

|  |  |  |
| --- | --- | --- |
| **Does the CYP have a current Care Plan?** | **YES** | **NO** |
| If **YES**, please attach. If **NO**, please outline current input and goals: | | |
| Click here to enter text. | | |

**Other involved Professionals Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** | Click here to enter text. | | | | **Tel No:** | Click here to enter text. |
| **Professional Designation:** | | Click here to enter text. | | | | |
| **Address:** | Click here to enter text. | | | | | |
| **Postcode:** | Click here to enter text. | | | **Email:** | Click here to enter text. | |
| **Name:** | Click here to enter text. | | | | **Tel No:** | Click here to enter text. |
| **Professional Designation:** | | Click here to enter text. | | | | |
| **Address:** | Click here to enter text. | | | | | |
| **Postcode:** | Click here to enter text. | | | **Email:** | Click here to enter text. | |
| **Name:** | Click here to enter text. | | | | **Tel No:** | Click here to enter text. |
| **Professional Designation:** | | Click here to enter text. | | | | |
| **Address:** | Click here to enter text. | | | | | |
| **Postcode:** | Click here to enter text. | | | **Email:** | Click here to enter text. | |
| **Name:** | Click here to enter text. | | | | **Tel No:** | Click here to enter text. |
| **Professional Designation:** | | | Click here to enter text. | | | |
| **Address:** | Click here to enter text. | | | | | |
| **Postcode:** | Click here to enter text. | | | **Email:** | Click here to enter text. | |
| **Name:** | Click here to enter text. | | | | **Tel No:** | Click here to enter text. |
| **Professional Designation:** | | | Click here to enter text. | | | |
| **Address:** | Click here to enter text. | | | | | |
| **Postcode:** | Click here to enter text. | | | **Email:** | Click here to enter text. | |
| **Name:** | Click here to enter text. | | | | **Tel No:** | Click here to enter text. |
| **Professional Designation:** | | | Click here to enter text. | | | |
| **Address:** | Click here to enter text. | | | | | |
| **Postcode:** | Click here to enter text. | | | **Email:** |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Has there been any previous CAMHS (not FCAMHS) contact?** | | | |
| **YES** | | **NO** | **NOT KNOWN** |
| **If YES, please attach any available information/reports** (eg. chronology, psychiatric, psychological, assessment reports etc) | | | |
| **Attached:** | Click here to enter text. | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CYP: Living Arrangements at time of referral** | | | | | | | |
| **Family Setting:** | | **Birth family** |  | **Adoptive Family** |  | **Other Family** |  |
| **Foster care** |  | **Residential Care** |  | **Residential School** |  | Click here to enter text. | |
| **Secure Care (Welfare)** |  | **Independent Living** |  | **Semi-independent Living** |  |
| **Criminal Justice Setting:** | | **Secure Care (CJS)** |  | **STC** |  | **YOI** |  |
| **Mental Health Setting:** | | **Low/Medium Secure** |  | **Open Unit** |  | **PICU** |  |

|  |  |  |
| --- | --- | --- |
| **Is the CYP under the Mental Health Act?** | **YES** | **NO** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CYP: Social Care Status at time of referral** | | | | | | | | |
| **LAC S20** |  | | **LAC S31** |  | **Leaving Care** |  | **Guardianship Order** |  |
| **Subject to CP Plan** |  | | **Secure Accommodation Order** |  | **TAC** |  | **None** |  |
| **Other** (please state) | |  | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CYP: Education Status at time of referral** | | | | | | | | | | |
| **NEET** |  | | **Special School** | |  | **Home Tuition** |  | **Unit** | |  |
| **Mainstream** |  | | **Mainstream SEN** | |  | **College FE** |  | **Vocational Training** | |  |
| **Employed (has left school)** | | | | |  | **EHCP** **YES** | | | **NO** | |
| **Other** (please state) | |  | | Click here to enter text. | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CYP: Criminal Justice Status at time of referral** | | | | | | |
| **Not Applicable** |  | **On Bail** |  | | **Recent Police Contact** |  |
|  |  |  |  | |  |  |
| **Community Order** |  | **Other** (please state) **:** |  | Click here to enter text. | | |

**Reason(s) for Referral** (Please provide detailed information under the headings provided)

|  |
| --- |
| **Details of the current presenting issue(s), including any risk concerns and diagnosed physical and/**  **or mental health conditions (please also attach the current risk assessment)** |
| Click here to enter text. |
| **Details of the CYP’s background, including family history/upbringing, lifestyle and socialisation** |
| Click here to enter text. |
| **Details of what appears to have reinforced/maintained current issues, eg. peer group, substance use etc** |
| Click here to enter text. |
| **Details of the CYP’s protective factors, eg. support people or skills they may have developed etc** |
| Click here to enter text. |
| **Details of current interventions provided to the CYP and the CYP’s level of participation in these.**  **Please mention if the CYP has a current care plan** |
| Click here to enter text. |
| **Details about your anticipated outcome from The Port FCAMHS** |
| Click here to enter text. |

Thank you for making a referral to **The Port FCAMHS**. We will be in contact within 5 working days to provide you with feedback on the outcome of your referral. We may also be in contact to request additional information in order to assist with referral intake purposes.

**Please return your completed referral form via secure email to** [**portman.fcamhs@nhs.net**](mailto:portman.fcamhs@nhs.net) **from an nhs.net account or one of the secure email accounts listed below:**

**nhs.net / cjsm.net / gcsx.gov.uk / gse.gov.uk / gsi.gov.uk / gsx.gov.uk / hscic.gov.uk / mod.uk / pnn.police.uk / scn.gov.uk**

**If you do not have access to one of the above accounts – please send your referral form and any sensitive attachments via post to the address above, or via email as password protected documents. Please send the password to** [**portman@tavi-port.nhs.uk**](mailto:portman@tavi-port.nhs.uk) **Subject: FAO FCAMHS Referrals Coordinator or call us with details on 020 8938 2089 (you may leave a voicemail if you wish). Thank you.**

**OFFICE USE ONLY:** Info check at consultation