**Return completed form to:** 

**Email:** portman.fcamhs@nhs.net **The Port (FCAMHS)** Portman Clinic

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

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| **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. |

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| Has consent been obtained for this referral to FCAMHS? | **YES** |[ ]  **NO** |[ ]
| If YES, please name the person giving consent: | Click here to enter text. |
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| **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 making this referral to our service, and the sharing of appropriate information across agencies involved.** |

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| **Child/Young Person (CYP) Information** | **Please complete as fully as possible** |

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| **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:** | Click here to enter text. | **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. |

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| **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. |

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

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| **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**

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| **Name:** | Click here to enter text. | **Tel No(s):** | Click here to enter text. |
| **Title/Professional Designation:** | Click here to enter text. |
| **Service:** | 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 and Service:** | Click here to enter text. |
| **Capacity** (eg. Co-worker/Manager)**:** | Click here to enter text. | **Tel No:** | Click here to enter text. |

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| **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. |

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

**Other involved Professionals Information**

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| **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. |

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| **Has there been any CAMHS (not FCAMHS) contact?** |
| **Current CAMHS**  | **YES** [ ]  **NO** [ ]  | **Previous CAMHS**  | **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. |
| **Is the CYP under the Mental Health Act?** | **YES** [ ]  **NO** [ ]  | **Not Known** [ ]  |

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| **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**  | [ ]  |

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| **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) | Click here to enter text. |

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| **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. |

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| **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)

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| **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. |

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| **Please let us know how you know / where you heard about ( The Port North Central North East London FCAMHS)** | **Have you used this service before?****YES** [ ]  **NO** [ ]  |
| 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** **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 secure accounts – please send your referral form as a password protected document, encrypted with EGRESS or via post to the address above. Please send the password in a separate email or call us on 020 8938 2089 (you may leave a voicemail if you wish). Thank you.**

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