**Referral to the Child, Young Adult and Family Services**

**All sections of the form are compulsory and must be completed to ensure the referral is accepted.**

Fields highlighted in blue (\*) are required. In order to successfully save this document, please ensure the required fields are completed.

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| **Date of Referral**  | Click here to enter a date. |  |

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| **Section 1: Patient Details** |
| **Has the family/young person agreed to this referral? (\*)** | [ ]  Yes |   [ ]  No |
| **Who has given consent for this referral?** |  |
| **Full Legal Name (\*)** |  | **Date Of Birth** |  Click here to enter a date. |
| **Preferred name** (if different) |  | **Sex assigned at Birth (\*)** | [ ]  Male  | [ ]  Female |
| **Address**  |  | **NHS Number**  |  |
| **Post Code** |  | **Patient Phone / Mobile (\*)**  |  |
| **Patient Email**  |  | **Carer Phone / Mobile (\*)** |  |
| **Interpreter Required? (\*)** | [ ]  **Yes** | [ ]  **No** | **If required, what language**  |  |
| **Do the patient have any other communication support needs? (\*)**  | [ ]  **Yes** | [ ]  **No** | **If yes, please give more information** |       |
| **Who does CYP live with?** |       | **Is the referred CYP an ex-member of British armed forces or dependent on such a person? (\*)** | [ ]  **No**[ ]  **Unknown**[ ]  **Yes, ex-services member** [ ]  **Yes, dependant of an ex-services member** |
| **Ethnicity \*** | Choose an item. |
| ***Patients 18 and over*** | **Marital status \*** | Choose an item. | **Current accommodation***Living alone/ with friends or family etc.* | Choose an item. |
| **Employment status \*** | Choose an item. |

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| **Family Members** *relevant to referral* | **Relationship** | **Living at above address Y/N**  | **DOB** | **M/F** |
| **First Name** | **Surname** |
|       |       |       |       | Click to enter date |       |
|       |       |       |       | Click to enter date |       |
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|       |       |       |       | Click to enter date |       |
| **Who has Parental Responsibility? (\*)**  |       |
| **Please tick those that apply:** |
| **Child in Need** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Child Protection Plan** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Looked After Child** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Special Guardianship Order** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Residence Order** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Adopted** | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Youth Offending Order**  | [ ]  **Yes** | [ ]  **No** | [ ]  **Historic** |
| **Previous CAMHS Involvement** | [ ]  Yes | [ ]  **No** | [ ]  **Historic** |

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| **Section 2: Primary Reason for referral (mandatory NHSEi Information) Please select only one main reason (\*).** |
| [ ]  First Episode Psychosis  | [ ]  Adjustment to health issues | [ ]  Anxiety |
| [ ]  Attachment Difficulties | [ ]  Bi polar disorder | [ ]  Conduct disorder |
| [ ]  Depression/ low mood | [ ]  Drug and Alcohol  | [ ]  Eating disorders |
| [ ]  Family relationship difficulties | [ ]  Gender discomfort  | [ ]  In crisis  |
| [ ]  Neurodevelopmental conditions  | [ ]  Obsessive compulsive disorder  | [ ]  Ongoing or Recurrent Psychosis  |
| [ ]  Organic Brain disorder | [ ]  Perinatal mental health issues | [ ]  Personality disorders  |
| [ ]  Phobias | [ ]  Post-traumatic stress disorder | [ ]  Self-care issues |
| [ ]  Self-Harm behaviours | [ ]  Unexplained physical symptoms  |

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| **Section 3: Pre-referral discussion –**  |
| **Has there been a Pre-referral Discussion**  | [ ]  Yes | [ ]  **No** |  |
| **If yes, who was the discussion with?** |       |
| **Date of discussion**  | Click here to enter a date. |
| **If “Yes”, and a referral has been agreed to, what was the agreed plan, and which CAMHS team, and which CAMHS practitioner will be allocated?** |
|       |
| **If Section 3 has been completed move to Section 5** |

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| **Section 4: Referral Information** |
| **What are you thinking CAMHS can do that would be helpful?**  |
|       |
| **Please describe the current emotional/behavioural difficulties, how severe they are, what impact they have on functioning (school, home life, etc.), how long they have been present, and any issues about risk to self or others.** |
|       |
| **What has been done already to try and help, what other services have the family worked with and what was the outcome? If there were previous referrals to CAMHS, what happened?** |
|       |

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| **Section 5: Professional Network** |
| **GP Details** |
| **GP Name**  |  | **GP Practice Name**  |  |
| **GP Address**  |  | **GP Telephone**  |  |
|  |  | **Permission to Contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |
| **School Details** |
| **School (\*)** |  | **Name of School Contact** |  |
| **School Address (\*)** |  | **School Telephone** |  |
|  |  | **Permission to Contact? (\*)** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |

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| **Referrers Details** (*only if the referrer is* ***not*** *the patient’s GP)* |
| **Referrer Name** |  | **Referrer Job Title** |  |
| **Referrer Address** |       | **Referrer Email**  |  |
| **Referrer Telephone**  |  |
| **Permission to contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |

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| **Section 5 Cont - Other Services/ Professionals Involved:** |
| **Name** |  | **Address** |  |
| **Service** |  |
| **Contact no** |  | **Permission to contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |

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| --- | --- | --- | --- |
| **Name** |  | **Address** |  |
| **Service** |  |
| **Contact no** |  | **Permission to contact?** | [ ]  **Yes**  | [ ]  **No** | [ ]  **Don’t Know** |

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| ***Office use only***  |
| **Clinician** |  | **Appointment date** | Click here to enter a date. |
| **Codes: Referral problem** |  | **Referral reason** |  |
| **Client No.** |  | **CAMHS’s action** |  |

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| **Referrer’s Signature:\*** | **Referrer’s Job Title** | **Date:** |
| **Option1:****I (upload image of signature)****OR** **Option2:** Type name here  **(enter name)** |  | Click here to enter a date. |

Camden Joint Intake –referrals

120 Belsize Lane

London, NW3 5BA

Email: tpn-tr.CYAF-Intake@nhs.net