**Referral to the Adolescent and Young Adult Service**

**For more information about our service see:**

<https://tavistockandportman.nhs.uk/services/adolescent-and-young-adult-service-ayas/>

**The Adolescent and Young Adult Service offers psychoanalytic therapies for young people aged between 14 and 25 wanting to understand the links between their early experiences and current difficulties. These kinds of therapies (which we offer to individuals, groups and families) provide a space in which to explore thoughts and emotions, including past and present experiences, in order to try to help an individual understand themselves more fully, as a way to address their difficulties. This less-structured, exploratory approach can be helpful in addressing deep-seated patterns that link to early childhood experience, the repetition of which can have an impact on emotions, mental health and interpersonal relationships. We also sometimes see parents on their own if that seems helpful.**

**Our therapy appointments are offered in person at our clinic (and not via phone or video call). Our clinic hours are Monday to Friday 9-5pm. The therapies we offer include longer term options (12-18 months) as well as shorter term options. Patients need to be able and willing to commit to attending weekly sessions in person, for the duration of the therapy.**

**A young person needs to be in a stable enough situation in order to engage in a treatment which focusses on distressing experiences and may increase anxiety as part of the process (e.g. stable housing, no active psychosis, no harmful use of alcohol or substances, no active eating disorders, no current crises).**

**Although many of our patients have experienced serious and complex childhood adversity, we do not offer trauma focussed work eg EMDR / trauma-focussed CBT, for which a referral to alternative services would be appropriate.**

**Please note that we do not offer CBT or DBT, and we are not a diagnostic service for ASD, ADHD or personality disorders.**

**We also do not accept patients who are currently receiving psychotherapeutic input from another service. Where a young person is close to the ending of a course of psychotherapy, please consider the importance of allowing time and space for that experience to end and be digested before seeking a referral for further therapy.**

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| **Date of Referral** |  |  |

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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** |  | **D.O.B** |  |
| **Preferred name** *(if different)* |  | **Sex assigned at Birth**  | [ ]  **Female** | [ ]  **Male** |
| **Address**  |  | **Patient Phone / Mobile** |  |
| **Carer Phone / Mobile** |  |
| **NHS Number** |  | **Patient email** |  |
| **Int*e*rpreter Required?** | [ ]  **Yes** | [ ]  **No** | **If required, what language** |  |
| **Does the patient have any other communication support needs**? | [ ]  **Yes** | [x]  **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**[ ]  **Don’t Know** [ ]  **Yes, ex-services member**[ ]  **Yes, dependant of an ex-services member** |
| **Please choose an ethnicity code which best reflects the ethnicity of the referred child.**  |  | The Tavistock and Portman NHS Foundation Trust is focusing on access to services as part of our PCREF\* developments. It is important that this information is provided at the point of referral so we can work towards ensuring the services provided meet the needs of our local population. Please can you ensure this data is included |
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| **Ethnicity codes** |
| (A) White British(B) White Irish(C) Other White background(D) White and Black Caribbean | (E) White and Black African(F) White and Asian(G) Other mixed background(H) Indian | (J) Pakistani(K) Bangladeshi(L) Other Asian background(M) Caribbean | (N) African(P) Other Black background(R) Chinese(S) Any other ethnicity group |

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| ***Patients 18 and over*** | **Employment status** |  | **Current accommodation***Living alone/ with friends or family etc.* |  |
| **Marital status** |  |
| **Family Members** *relevant to referral* | **Relationship** | **Living at above address Y/N**  | **DOB** | **M/F** |
| **First Name** | **Surname**  |
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| **Who has Parental Responsibility?**  |  |

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| **Please tick those that apply (current or historical):** |
| **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 2: Reason for referral****Please describe the current emotional/behavioural difficulties, 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.** |
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| **Section 3: Pre-referral discussion with a member of the AYAS team**  |
| **Has there been a Pre-referral Discussion with a member of the AYA team?** | [ ]  **Yes** | [ ]  **No** |  |
| **If yes, who was the discussion with?**  |  |
| **Date of discussion**  |  |
| **If “Yes”, has the referral been agreed to, what was the agreed plan:** |
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| **Section 4: Referral Information** |
| **It would be helpful for us to have the following information, if possible:*** **Why do you think an exploratory space would be helpful for this young person?**
* **Is the young person aware of the referral and consents to it?**
* **What additional support might the young person require to engage in an exploratory therapy?**
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| **Medical, psychiatric and psychotherapeutic history****Please include information about previous difficulties/diagnosis.** **What has been done already to try and help, what other services have they worked with and what was the outcome? Please also include information about current medication.**  |
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| **Information on family, early history, relationships, social circumstances and any experience of discrimination**  |
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| **Any other relevant information of comments – please include understanding of plans for next 18 months e.g leaving London for university / having completed university / going travelling etc.**  |
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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/college/university Details** |
|  **School** |  | **Name of School Contact**  |  |
| **School Address** |  | **School Telephone** |  |
| **Permission to Contact?** | [ ]  **Yes** | [ ]  **No** | [ ]  **Don’t Know** |
| **Referrer 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** | [ ]  N**o** | [ ]  D**on’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** | **DD / MM / YYYY** |
| **Codes: Referral problem** |  | **Referral reason** |  |
| **Client No.** |  | **CAMHS’s action** |  |

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| **Once completed send to:** |
| **Email** | tpn-tr.CYAF-Intake@nhs.net |
| **Post** | Camden Joint Intake –referrals120 Belsize LaneLondon, NW3 5BA |

\*PCREF – Patient and carer race equalities framework

[NHS England » Patient and carer race equality framework](https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref/)