Haringey Child & Adolescent Mental Health Service

**REFERRAL FORM**

**Haringey CAMHS Access**

Please complete and return to Referrals Administrator

Child & Adolescent Mental Health Service, Ground Floor, M Block, St Ann’s Hospital, St Ann’s Road, London N15 3TH

(Tel No: 020 8702 3400)

or email to: [beh-tr.camhsreferral@nhs.net](mailto:beh-tr.camhsreferral@nhs.net)

**REFERRER INFORMATION**

|  |  |
| --- | --- |
| **Name of Referrer**  **Position**  **Address** | **Tel No:**  **Fax No** |

**CLIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of referred child/young person** | | **Date of Birth** | **MALE / FEMALE** |
| **Current Address**  **Postcode** | | **Home telephone** | **Client mobile no:** |
| **Ethnicity** | **Main language spoken** |
| **NHS Number** | **Interpreter needed?**  **YES / NO** |
| **Has the child/young person (if appropriate) agreed to this referral?**  **YES / NO** | | **Are they able to travel to appointments:**  **YES / NO** | |
| **Name and address of GP** | **Name and address of school/college** | | | |

**PARENT/GUARDIAN/CARER INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Who does the young person live with?**  **NAME RELATIONSHIP** | | | **Did they agree to this referral?**  **YES / NO** | | **Accommodated by Local Authority?**  **YES / NO** |
| **Mobile No:** | **Ethnicity** | | **Main language spoken** | | **Interpreter required?**  **YES / NO** |
| **Who should correspondence be addressed to? (i.e. carer and child, mother and child, father and child, parents and child, other):** | | | | | |
| **Name of person(s) with parental responsibility (if different from above)**  **NAME RELATIONSHIP** | | | | **Are they aware of this referral?**  **YES / NO** | |
| **Address (if different to above)** | | | | | |
| **Other members of the household (please list)**  **NAME RELATIONSHIP** | | **Significant others not in household (please list)**  **NAME RELATIONSHIP** | | | |

**REFERRAL INFORMATION**

|  |
| --- |
| **REASON FOR REFERRAL (e.g. presenting problem, duration, severity, including nature of mental health concerns)** |
| **BACKGROUND HISTORY (e.g. significant family difficulties, bereavement, illness, parental separation, changes at home or school, placement etc):** |
| **WHAT IS THE REFERRER HOPING TO ACHIEVE BY MAKING THIS REFERRAL?** |
| **RELEVANT MEDICAL HISTORY/CURRENT MEDICATION** |

LEGAL STATUS OF YOUNG PERSON

(**Please complete/tick as appropriate**)

|  |  |
| --- | --- |
| **Name of Social Worker**  **Address** | **Tel:**  **Fax :** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there any pending Court proceedings?** | **Yes** |  | **No** |  |
| **If “yes”, please give details (e.g. youth offending, care proceedings, etc.)** | | | | |
| **Dates of any fixed hearings** |  | | | |
| **If the young person is “looked after” by the Local Authority, is there a care plan** | **Yes** |  | **No** |  |
| **If “yes”, does the care plan propose a referral for a mental health assessment** | **Yes** |  | **No** |  |
| **Is the young person on the Child Protection Register?** | **Yes** |  | **No** |  |
| **If “yes” – under what category of registration** |  | | | |
| **Nationality of young person** |  | | | |
| **Immigration status of young person** |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Is the Young Person Statemented? | | **Yes** |  | | **No** |  |
| **Are there other Professionals involved with the Young Person?** | | **Yes** |  | | **No** |  |
| If “yes”, please tick the appropriate box and give the relevant details | | | | | | |
| Professional | **Current contact – name** | | | **Past contact – name & year** | | |
| Psychiatrist |  | | |  | | |
| Clinical Psychologist |  | | |  | | |
| Educational Psychologist |  | | |  | | |
| Family Therapist |  | | |  | | |
| **Educational Welfare Officer - EWO** |  | | |  | | |
| **Community Psychiatric Nurse – CPN/CMHN** |  | | |  | | |
| Residential Key Worker |  | | |  | | |
| Guardian ad litem |  | | |  | | |
| **Child & Adolescent Mental Health Service** |  | | |  | | |
| Youth Offending Services |  | | |  | | |
| Other |  | | |  | | |
| **Does the young person/ parent/carer have a disability? Please provide details.** |  | | | | | |

Risk Assessment Form ***( to be completed for all referrals***)

|  |  |  |
| --- | --- | --- |
| Factors | History | If yes, please describe |
| **Violence to others** | **Yes No**  **❑ ❑** |  |
| **Cruelty to animals** | **Yes No**  **❑ ❑** |  |
| **Use/collection/carrying of weapons** | **Yes No**  **❑ ❑** |  |
| **Self Neglect** | **Yes No**  **❑ ❑** |  |
| **Deliberate self harm** | **Yes No**  **❑ ❑** |  |
| **Deliberate fire setting** | **Yes No**  **❑ ❑** |  |
| **Substance Use/Misuse** | **Yes No**  **❑ ❑** |  |
| **Poor supervision at home** | **Yes No**  **❑ ❑** |  |
| **Exploitation or abuse (physically/emotionally/**  **sexually)** | **Yes No**  **❑ ❑** |  |
| **Inappropriate behaviour (e.g. sexual)** | **Yes No**  **❑ ❑** |  |
| **Psychotic symptoms (e.g. hearing voices)** | **Yes No**  **❑ ❑** |  |
| **Interfamilial discord** | **Yes No**  **❑ ❑** |  |
| **Family history of mental health problems** | **Yes No**  **❑ ❑** |  |
| **Family history of self harm or suicide** | **Yes No**  **❑ ❑** |  |
| **Family history of substance misuse** | **Yes No**  **❑ ❑** |  |
| **Witness to violence** | **Yes No**  **❑ ❑** |  |
| **Criminal activity** | **Yes No**  **❑ ❑** |  |
| **School Exclusion/Non attendance** | **Yes No**  **❑ ❑** |  |
| **Lack of social support (e.g. family or friends)** | **Yes No**  **❑ ❑** |  |
| **Poverty/unemployment in family** | **Yes No**  **❑ ❑** |  |

**Information Sources Available/Accessed**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Young Person** | **❑** | **Carer/Relative** | **❑** | **Social Services** | **❑** |
| **Education** | **❑** | **Community/Consultant Notes** | **❑** | **Police/Probation Services** | **❑** |

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Copies of this form can be downloaded from the BEH-MHT Website/Resources/Haringey CAMHS Referral Form.**

**For referrals from Education Only.**

**Are there other professionals within education involved?**

|  |  |
| --- | --- |
| **SENCO** |  |
| **SCHOOL NURSE** |  |
| **SPEECH AND LANGUAGE THERAPIST** |  |
| **SCHOOL COUNSELLOR** |  |
| **BEST** |  |

**Have you discussed this referral with other Education Professionals involved?**

**Attainment levels:- SATS**

**READING Age**

**SPELLING Age**

**Any concerns regarding Learning Difficulties?**