**CAMHS REFERRAL FORM**

Referrals are accepted from any professional involved with a child, such as Social Workers, Health Visitors, School Staff, Doctors, Educational Psychologists, Early Help Workers and Counsellors.

For advice on completing this referral form, please contact a CAMHS Specialist Community Advisor or Duty Worker:

Chesterfield, North East Derbyshire & Bolsover Tel: 01246 514412 or

High Peak and North Dales Tel: 01298 72445

Are you referring to Specialist CAMHS or Targeted Intervention Community Triage?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **REFERRED CHILD’S DETAILS** | | | | | |
| Forename of Child |  | | | | |
| Surname of Child |  | | | | |
| Parent(s)/Carer(s) with parental responsibility  Full Name(s) |  | | | | |
| Child’s Address :  Postcode: |  | | | | |
| DOB: |  | | | | |
| Gender: |  | | | | |
| NHS Unique Number:  (if known) |  | | | | |
| Telephone Numbers |  | | | | |
| GP Details:  (Address and contact numbers, if known): |  | | | | |
| Ethnicity: |  | | | | |
| School: |  | | | | |
| How long has the family lived in the UK? |  | | | | |
| **REASON FOR REFERRAL/MENTAL HEALTH CONCERNS** | | | | |
| **Please indicate significant concerns and needs by circling or highlighting any of the following:** | | | | |
| Low mood/severe mood swings | | | Anxiety/phobias | Trauma symptoms (PTSD) |
| Obsession and/or compulsions | | | Suicidal thoughts/threats | Self-harm |
| Hallucinations or delusions | | | Hearing voices | Eating/weight/body image\* |
| Sleep Problems | | | Vocal or motor tics | Hyperactivity/Poor concentration |
| **Please describe the child/young person's presentation in detail e.g. What does their behaviour look like?**  **How does this impact on their daily functioning?** | | | | |
| **What areas of the child’s life do the concerns present?**  *(e.g. school, home and social areas)* | | | | |
| **How long has the issue been present?** | | | | |
| **Health and Development**  *\*Please include, or ask GP for serial height and weight details, if there are concerns about eating* | | | | |
| **Details of any current medication:** | | | | |
| **Does the child have an EHCP or GRIP?** YES/NO If so, please give details: | | | | |
| **Is the child a Looked After Child?**  YES /NO If so, please provide Social Worker’s details:  Is the child placed in Derbyshire from out of area? If so, has funded been agreed for local CAMHS input? YES /NO | | | | |
| **Is the child on a Child Protection Plan?** YES /NO If so, please provide Social Worker’s details:  Have there been any safeguarding concerns in the past? | | | | |
| **Is the family known to any other agencies?**  **What support have they already accessed and from which service?** | | | | |
| **Additional information**  **Please include details** **about the child’s circumstances or family history that is relevant to the referral.** | | | | |
| **CONSENT -Required for all referrals**  Please note that a referral declined by CAMHS may be shared with our community partners, e.g. Children’s Services, School Health and Action for Children in order to seek advice as to the best agency to offer a service should CAMHS not be able to help. | | | | |
| **Consent to referral obtained from young person and /or person with Parental Responsibility**  Confirm with signature: ……………………………………………………………………………….Parent/Young person  Date consent obtained: ……………………………………………………………………………….. | | | | |
| **Consent to gather information and share between services agreed**  Confirm with signature: ………………………………………………………………………………..Parent/Young person  Date consent obtained: ………………………………………………………………………………… | | | | |
| Referrer’s name: | |  | | |
| Referrer’s Job Title | |  | | |
| Referrer’s Address | |  | | |
| Referrer’s email and telephone number | |  | | |
| **Date of referral:** | |  | | |

**Thank you**

**Please post to the CAMHS team where the child lives:**

**Chesterfield and North Derbyshire:**

CAMHS

2nd Floor, The Den

Chesterfield Royal Hospital

Calow, Chesterfield

S44 5BL

**High Peaks and Dales:**

CAMHS

New Spring House

Bath Road

Buxton

SK17 6HL

**Please also send a copy the child’s GP to keep them informed.**