**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.

**Please contact a CAMHS Specialist Community Advisor or Duty Worker prior to completion:**

**Email: CRHFT.camhsscas@nhs.net or Tel: 01246 514412 or 01298 72445**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: |  | | | |
| Telephone Numbers:  Parent  CYP  Email Address: |  | | | |
| Gender at birth: |  | | | |
| NHS Unique Number:  (if known) |  | | | |
| GP Details:  (Address and contact numbers, if known): |  | | | |
| Ethnicity: |  | | | |
| First Language: |  | | | |
| School:  (Please tell us the name of the school the child/young person is attending) |  | | | |
|  | Permission to speak to school given by parent/young person: **YES/NO**  If YES, please give a contact name here………………………………………………… | | | |
| **REASON FOR REFERRAL/MENTAL HEALTH CONCERNS** | | | | |
| **Please indicate the main concerns by circling or highlighting any of the following:** | | | | |
| Low mood/severe mood swings | | | Suicidal thoughts/threats | Self-harm |
| Anxiety/phobias | | | Obsession and/or compulsions | Trauma symptoms (PTSD) |
| Hallucinations or delusions | | | Hearing voices |  |
| Vocal or motor tics | | | Hyperactivity/Poor concentration | Eating Disorder or weight/body image concerns \* |
| **Please give further details of the concerns that have been circled/highlighted above**  *E.g., what are their thoughts and feelings and how are these presenting?*  **How does this impact on their daily functioning, at school, home, and social environments?**  *E.g., eating, sleeping, relationships with others, attendance at school, etc.* | | | | |
| **How long has the issue been present?** | | | | |
| **What support has the child or family already accessed and from which service?**  ***E.g. Early Help, parenting workshops, school counsellor, Build Sound Minds, and when*** | | | | |
| **Health and Development**  ***E.g. does the child have a neurodevelopmental diagnosis, or any physical health needs***  *\*If there are concerns about eating, please advise the family to have an in-person physical health assessment with their GP to gather serial height and weight details and any other medical monitoring. For more guidance, please contact the Eating Disorders Team directly on 01246 514412* | | | | |
| **Details of any current medication and who is the prescriber:** | | | | |
| **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, where:…………………………………………………..  Has funding been agreed for local CAMHS input by the originating Local Authority? YES /NO | | | | |
| **Is the child open to Children’s Services (Social Care)?** YES /NO  If so, please provide Social Worker/Early Help Worker details:  **Are there any current or historical safeguarding concerns?**  **Is the child open to Youth Offending Services? YES/NO** | | | | |
| **Is the child or family known to any other agencies?**  ***E.g. substance misuse services, adult mental health services, etc.*** | | | | |
| **Additional information**  **Please include details** **about the child’s circumstances, recent events/triggers or family history that is relevant to the referral.** | | | | |
| **CONSENT - Required for all referrals**  Please note that a referral not accepted by CAMHS may be shared with our community partners, e.g. Children’s Services, School Health and Action for Children in order to identify the best agency to help meet the child’s needs. | | | | |
| **Consent to referral obtained from young person and/or person with Parental Responsibility**  Confirm with signature: ………………………………………………………………………………. Parent/Young person  Date consent obtained: ………………………………………………………………………………    **Is the young person aware of this referral? YES/NO** | | | | |
| **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:** | |  | | |

**How to get your referral to us:**

**Email:** [**crhft.CAMHSreferral@nhs.net**](mailto:crhft.CAMHSreferral@nhs.net)

(Please check the security of your email provider and consider using a password protected email to ensure safety of confidential information) or

**Post to either of the CAMHS teams:**

**Chesterfield and North Derbyshire:**

CAMHS

2nd Floor, The Den

Chesterfield Royal Hospital

Calow,

Chesterfield

S44 5BL

**High Peak and Dales**

CAMHS

New Spring House

Bath Road

Buxton

SK17 6HL

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