**Specialist Child & Adolescent Mental Health Service (CAMHS)**

# **CAMHS REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| Bradford Office | Fieldhead House2-8 St Martins AvenueBradfordBD7 1LG | Keighley Office | HillbrookMayfield RoadOff Spring Gardens LaneKeighleyBD20 6LD |
| Telephone | 01274 723241 | Telephone | 01535 661531 |
| FaxDuty Times | 01274 21566409:00-17:00Monday-Friday | FaxDuty Times | 01535 69119409:00-17:00Monday-Friday |

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| --- |
| In crisis or significant risk of harm, the First response service will be able to help on: **01274 221181** |

**After completing this form and any additional supporting information, please return to your local CAMHS Service as mentioned above by mail or fax.**

*We are required to register the full demographic details (including area of residency, GP details and NHS number) of all referrals. Please include this information in your referral otherwise we will need to return this form to you prior to triage.*

*It is important that the following information is provided in as much detail as possible, to enable the referral to be comprehensively triaged and children & families can get the right service in the timeliest way.*

Please return the completed form to the above-mentioned address. If the referral does not meet the criteria for any of the Trust’s commissioned services, we will reply and inform you. ***(For further information, please see service criteria on the last page of this document)***

# **Section 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral** | Click or tap to enter a date. | **Date Received in CAMHS** | Click or tap to enter a date. |
| **Priority** | Routine [ ]  | Urgent [ ]  |  |

## **Child/Young Person’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | Click or tap here to enter text. | Surname | Click or tap here to enter text. |
| Preferred Name | Click or tap here to enter text. | Religion | Choose an item.  |
| Date of Birth | Click or tap to enter a date. | NHS No. | Click or tap here to enter text. |
| Gender | Choose an item. | Ethnicity | Choose an item. |
| Language *(inc. signing)* | Click or tap here to enter text. | Interpreter Required | Choose an item. |

|  |  |
| --- | --- |
| School/College attended: | Click or tap here to enter text. |
| Contact Name: | Click or tap here to enter text. | Tel No. | Click or tap here to enter text. |
| Attendance Difficulties: |   | Attainment Difficulties: |   |

## **Child/Young Person’s Complexity**

|  |  |
| --- | --- |
| Child Protection |[ ]  Learning Disability |[ ]
| Child in Need Plan |[ ]  Youth Offending |[ ]
| Education Health & Care Plan |[ ]  Refugee or Asylum Seeker |[ ]
| Young Carer Status |[ ]  Serious Physical Health |[ ]
| Parental Health Issues |[ ]  Kinship Placement |[ ]
| **Please complete the Information/Documents Required \* for the following complexities** |
| Looked After Child **\*** |[ ]  Adopted **\*** |[ ]
| Special Guardianship Order (SGO) **\*** |[ ]  Care/Arrangement Order **\*** |[ ]
| **Has the child/young person/family had previous involvement with CAMHS?** | Yes |[ ]  No |[ ]  Don’t Know |[ ]

## **Safeguarding**

|  |  |  |
| --- | --- | --- |
| **Have there been any safeguarding concerns about this child, or any other risks in this family?** *(e.g. parents with a history of violence)* | Yes |[ ]  No |[ ]
| *If yes, please describe and detail below any action taken:* |
| Click or tap here to enter text. |

## **Parent(s)/Carer(s) Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Click or tap here to enter text. | Name | Click or tap here to enter text. |
| Parental Responsibility | Choose an item. | Parental Responsibility | Choose an item. |
| Address | Click or tap here to enter text. | Address | Click or tap here to enter text. |
| Home Tel | Click or tap here to enter text. | Home Tel | Click or tap here to enter text. |
| Work Tel | Click or tap here to enter text. | Work Tel | Click or tap here to enter text. |
| Mobile Tel | Click or tap here to enter text. | Mobile Tel | Click or tap here to enter text. |
| Another Tel | Click or tap here to enter text. | Another Tel | Click or tap here to enter text. |
| Who does the young person live with | Choose an item. | Child’s Address*(if different)* | Click or tap here to enter text. |
|  |  |  |  |
| No of Siblings | Choose an item. |  |  |
| Name | Click or tap here to enter text. | DOB/Age | Click or tap here to enter text. |
| Name | Click or tap here to enter text. | DOB/Age | Click or tap here to enter text. |
| Name | Click or tap here to enter text. | DOB/Age | Click or tap here to enter text. |

# **Section 2**

## **Referral Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Click or tap here to enter text. | Profession/ Agency | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Tel | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |

|  |  |
| --- | --- |
| GP Name | Click or tap here to enter text. |
| GP Address | Click or tap here to enter text. |
| Tel | Click or tap here to enter text. |

## **Referral Type**

|  |
| --- |
| **This section may require you to provide further information, please complete the Information/Documents Required where \* is indicated.** |
| **Presenting problem or reason for referral to CAMHS service** |  | **Severity** |
| Advice Only |[ ]   |
| Anxiety |[ ]    |
| OCD |[ ]    |
| Deliberate Self Harm |[ ]    |
| Depression |[ ]    |
| ADHD Assessment **\*** |[ ]    |
| Eating Issues (ED) **\*** |[ ]    |
| Extremes of Mood |[ ]    |
| Phobia or Habit Problems |[ ]    |
| Post-Traumatic Stress (PTSD) |[ ]    |
| Problems in Attachment or Relationships |[ ]    |
| Psychotic Illness |[ ]    |
| Autism Assessment **\*** |[ ]    |
| Behavioural Difficulties |[ ]    |
| Gender Identity Development Difficulties |[ ]    |
| Suicidal Ideas |[ ]   |
| Other *(Please Specify)*Click or tap here to enter text. |[ ]    |

|  |
| --- |
| **CAMHS will also see individuals with the following presentations, if there is evidence of co-morbidity with a serious mental health condition.** |
| Drug and alcohol problem |[ ]    |

## **Information/Documents Required \***

|  |
| --- |
| **ONLY COMPLETE this section if you have selected a presenting problem which requires additional information/documents *(marked \*)*** |
| **Presenting Problem** | **Documents Required** | **Included** |
| Autism/ADHD | SNAP (Parent & Teacher) |[ ]
|  | School Report |[ ]
|  | Developmental History | ☐ |
| Looked After ChildAdoptedSpecial Guardianship OrderCare/Arrangement Order | LAAC Supporting Form |[ ]

|  |
| --- |
| ***Templates: Please use the appropriate templates below to support your referral*** |

|  |
| --- |
|  |

|  |
| --- |
| **Eating Issues (ED) ONLY** |
| **Information Required *(if possible)*** |  |  |
| Current Weight | Click or tap here to enter text. |  |
| Current Height | Click or tap here to enter text. |  |
| Blood Results *(date of last routine bloods taken)* | Click or tap here to enter text. | Included [ ]  |
| Medication | Click or tap here to enter text. |  |
| Allergies | Click or tap here to enter text. |  |
|  | **Yes** | **No** | **Frequency per day/week** |
| Missing meals |[ ] [ ]  Click or tap here to enter text. |
| Restricting meals |[ ] [ ]  Click or tap here to enter text. |
| Binge eating |[ ] [ ]  Click or tap here to enter text. |
| Vomiting |[ ] [ ]  Click or tap here to enter text. |
| Laxatives |[ ] [ ]  Click or tap here to enter text. |
| Diuretics/Diet pills |[ ] [ ]  Click or tap here to enter text. |
| Excessive exercise |[ ] [ ]  Click or tap here to enter text. |

## **Other Professional/Service Involvement**

|  |
| --- |
| **Have other professional or services been involved to meet the needs of the child, young person or family?** |
| **Name** | **Agency** | **Tel** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Please provide details of any previous therapeutic involvement |
| Click or tap here to enter text. |

# **Section 3**

## **Difficulty/Issues Details**

|  |
| --- |
| **Please describe the problem and in what ways the problem is adversely affecting the child and family;** *(Please identify specific mental health concerns)* |
| **How long has the issue been going on, how often is it happening & how is it impacting?** |
| Click or tap here to enter text. |

## **Risk Factors**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Risk Factors** | **Yes** | **No** | **Not Known** | **If yes, please comment** |
| Suicidal thoughts |[ ] [ ] [ ]  Click or tap here to enter text. |
| Harm to self |[ ] [ ] [ ]  Click or tap here to enter text. |
| Harm to others |[ ] [ ] [ ]  Click or tap here to enter text. |
| Self-neglect |[ ] [ ] [ ]  Click or tap here to enter text. |

|  |
| --- |
| **Historical risk factors. Current risk factors, vulnerabilities etc.** |
| Click or tap here to enter text. |
| **Resilience - Protective factors (e.g. friendships, good family relationship’s)****What has / has not worked (e.g. taking time out when feels anxiety rising, school supporting workload, what is going well.** |
| Click or tap here to enter text. |

# **Section 4**

## **Expectations of CAMHS**

|  |
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| **What does the Young Person, Referrer & Carer(s) think will help?** |
| Click or tap here to enter text. |

## **Consent**

|  |  |  |
| --- | --- | --- |
| Has Consent for referral been given? | Yes |[ ]  No |[ ]
| If Yes, by whom *(name & relationship)* | Click or tap here to enter text. |
| Has the referral been discussed with the Child/Young Person? | Yes |[ ]  No |[ ]
| Is there parental consent for enquiry/onward referral to other agencies? | Yes |[ ]  No |[ ]

## **Declaration**

|  |  |
| --- | --- |
| Signed | Click or tap here to enter text. |
| Name | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |

# **Criteria for referral to CAMHS Service**

|  |  |  |  |
| --- | --- | --- | --- |
| CAMHS is a specialist service providing help for children and young people with considerable levels of difficulty. There is an expectation that in most cases the child and family will have received support by an earlier intervention service (see Other Services section below).**CAMHS may be able to help when:*** emotional problems which significantly affect a child’s daily life have persisted despi a school/community-based intervention (see OTHER SERVICES section in self-care; all/most family members highly distressed; non-school attendance as a result of mental health presentation; serious deterioration in academic attainment related to mental health presentation; social withdrawal - no contact with friends; relations with peers leading to serious risk-taking) OR
* there is a reasonable indication that the child may have complex neurodevelopmental difficulties e.g. autistic spectrum continuum, ADHD or other difficulties that may require a multi-disciplinary assessment.
 | CAMHS work with children and young people up to the age of 18 with:* Moderate/severe depression
* Attentional/hyperkinetic problems
* Assessment & diagnosis of Autistic spectrum disorders
* Moderate to severe anxiety
* Habit disorders
* Mental health problems with learning disabilities
* Eating disorders
* Significant attachment / relationship difficulties
* Obsessive Compulsive Disorder
* Psychosis

NHS Specialist CAMHS works with children and young people in most need of mental health services. Therefore, it does **NOT** offer a service for:1. normal reactions to adverse life events e.g. anxiety/distress following bereavement or divorce.
2. difficulties which are normal to children’s development, such as temper tantrums or oppositional teenagers.
3. difficulties which could be helped by services working in schools and children’s centres.
 | Services based within the local community, schools and children’s centres should be considered initially where low-level emotional problems exist. For example:* **Home life:** Arguing with siblings, upset following a death or divorce, behaviour problems in younger children, anger/ conflict between teenagers and parents
* **School:** Being teased, lack of confidence, school discipline problems with teenagers
* **Friendships:** Falling out with friends, jealousy, dating problems
* **Minor self-harming behaviour:** e.g. superficial cutting, absence of suicidal ideation

**Other services that can help**School nursing services are the first point of contact within Bradford for mental and emotional health issues unless in crisis or significant risk of harm where the First response service will be able to help on: **01274 221181** | **Charities & Voluntary Services:** Some charities in the local area offer counselling and therapeutic support to children and young people. **Private therapists:** Some families may want to pay for therapy for a child or young person. Costs vary but tend to be upwards of £45 for a single session. You can find details of private therapists on the website of the British Association for Counselling and Psychotherapy: [www.bacp.co.uk](http://www.bacp.co.uk)**Self-help resources:** Self -help resources for young people and parents/carers are available some useful sites include:<http://thrivebradford.org.uk><http://www.mymind.org.uk>**Support for parents and carers:** You can find out more by visiting:<http://bmywellbeingcollege.nhs.uk> or calling 0300 555 5551**Early Help**/Family Hub Services Bradford: 01274 432121,North Yorkshire: 01609 532412**CYP Interim Healthy Minds A5 Booklet Flyer:** |