*CAMHs office use
Date received:

NHS Dorset HealthCare University NHS Foundation Trust

Child and Adolescent Mental Health Service

REFERRAL FORM

For referral guidance please refer to the CAMHS Referral Guidance Booklet available online at: http://www.wheresyourheadat.co.uk/professionals

Please complete the form and return BY EMAIL to:

Bournemouth, Poole and Christchurch: dhc.camhsgateway.east@nhs.net	**West Dorset:** dhc.camhswest.admin@nhs.net
North Dorset: dhc.camhsnorthadmin@nhs.net	**Weymouth & Portland:** dhc.camhsadmin.weymouth@nhs.net
East Dorset & Purbeck: dhc.referralscamhs.eastdorsetlocality@nhs.net	

Referrer Information:	
Date referral made:	
Name of Referrer: **Job title:** **Address:**	**Tel No:** **Fax No (if relevant):** **Email address:**

(double click on relevant box and then select shade)
Have you met the child/young person that this referral relates to*: YES ☐ NO ☐

Has the child/young person agreed to this referral? YES ☐ NO ☐

*We would expect the referrer to have seen the CYP within the last 6mths at least and would not accept a referral if you have not met with the CYP prior to making this referral. If you have not met the CYP please provide details as to why.

(double click on relevant box and then select shade)
Is the parent/carer of the CYP aware of this referral being made? YES ☐ NO ☐

If no, please say why not:

Client Information:		
Name of Referred Child/Young Person:**	**Date of Birth:**	**Male / Female:**
Current Address: **Address for correspondence (if different):**	**Home Telephone*:** ***Main contact number is required if both are not known** **Ethnicity:**	**Contact Mobile No*:** **NHS Number:**
Name and address of school/college:		
Name and address of GP (if referral received from another source):		

Parent/guardian/carer information:		
Who does the young person live with? **NAME:** **RELATIONSHIP:** **PARENTAL RESPONSIBILITY: Yes/No/Not known** **If no: who has PR for the CYP:**	**Current contact number:** **(if different from above)**	**Ethnicity:** **(Mandatory)**

Other Family Members (if relevant to this referral)			
Name:	**Relationship:**	**Age (if known):**	**Male / Female:**

Reason for Referral:

Please describe your concerns about the child/young person's mental health and social wellbeing that have led to this referral being made, and what you are requesting from C-CAMHs. (Please include information on how long the difficulties have been present, in what settings the difficulties are evident, and what support/strategies have been tried so far).

So that we can best understand the clinical needs of the CYP*, please also provide details about the impact of the difficulties (e.g. increased risk to self), and information about what support is currently in place/has been offered e.g. online, community or school based resources.

* Please see screening checklist for guidance

Risk factors relating to the child/young person:	Yes	No	Not known
Significant/recurrent self-harm			
Suicidal ideation			
Child Sexual Exploitation (CSE)			
Risk towards others (Please give detail)			
Difficult to Engage			

Risk factors relating to the child/young person:			
	Yes	No	Not known

Care Status:

Looked after? (i.e. under care of Local Authority)	Has a CAF been completed? (If yes, please attach)
YES ☐ NO ☐	YES ☐ NO ☐
(e.g. foster/residential care or adoption)	

Local Authority Involvement:

Please outline any current involvement from social care in relation to the child/young person or family and/or if there are any current contextual factors that would be useful for us to know e.g. parental mental health needs, social risk factors (e.g. unemployment), additional physical health needs, maltreatment or exploitation.

Agencies/professionals known to be involved:

Please tell us what (if any) other agencies have been involved in supporting the child/young person and their family with the current difficulties:

	Yes	No	Contact name and address/number
Homestart or Portage			
Connexions			
Children's Centres			
Educational Psychology			
Autism Wessex			
Substance Misuse Services			
Paediatrics/Child Health			
Social Care			
School Health Team (nurses)			
School counselling/ELSA			
Family Partnership Zone			
Youth Offending Team			
Action for Children			
Dorset MIND			
Relate			
Other			

Please ask the child/young person and/or family to complete the following page to help provide us with extra information (if they wish to do so), and then submit the form via email.

For the child/young person and their parent/carer:

In your own words, please tell us about your difficult experiences at the moment, and what help you'd like to receive from the child and adolescent mental health service (sometimes it's hard to know what help you'd like, so please try to say how you'd like things to be different).

Other help you've tried or been offered:

So that we can know more about what other help you've tried/been offered, please tell us who else you've contacted, or what other services you've seen so far:

	Yes	No	Can you say any more about this?
I've used some apps on my phone			
I've read some books about what I'm going through			
I've looked at some websites that have been helpful			
I speak to teachers and other staff at my school			
I/my family have had some help from:			
Connexions			
Children's Centres			
Educational Psychology			
Autism Wessex			
Dorset MIND			
Substance Misuse Services			
Paediatrics/Child Health			
Social Care			
School Health Team (nurses)			
Family Partnership Zone			
Youth Offending Team			
Young Persons Eating Disorder Service			
Action for Children			
Other			

Your details:

Name of child/young person:
Parent/Carer:
Date:

<u>**Core Child and Adolescent Mental Health Service- Referral Guidance Tool**</u>

The checklist below can be used at the point of referral to establish what the level of need is, and whether involvement from C-CAMHs would be beneficial for the child/young person and family. There are many community based services (see checklist on referral form) that may be able to provide support to the CYP or family before seeking treatment within C-CAMHs, so if no other service has been involved to date please explore this with the family.

Impact and Duration

- ☐ Difficulties in emotional wellbeing have been present for 3 months or more (not in high risk cases and/or where dramatic change in mood or behaviour has been evident)
- ☐ Evidence to show that the difficulties are having a definite, noticeable and ongoing impact on the child's functioning
- ☐ Evidence that the difficulties are present in two or more areas of functioning: e.g. school, home, leisure and social situations
- ☐ Difficulties are worsening/persisting despite front line interventions being in place e.g. ELSA in school, community parenting support, GP directed self help

Context

- ☐ Evidence of difficulty within the family system e.g. parental mental health issues, maltreatment, social deprivation/neglect.
- ☐ Evidence of recent typical external stressors e.g. family breakdown, bereavement, exams, hospital visits (past or impending) where sufficient time has been allowed for the child to adjust and/or recover- no less than 3 months
- ☐ Concerns of risk that is ongoing e.g. domestic violence, physical chastisement, exploitation, risks posed by significant others
- ☐ Child is an unaccompanied asylum seeker