**Referral Form**

**Mental Health Support Team**

**Please complete all areas of the referral form and email the complete form to:**

**CAMHSWestMHSTReferrals@berkshire.nhs.uk**

**CAMHS Getting Help and Mental Health Support Teams - 0300 247 3002, Option 2**

(This is not a crisis number, for crisis number see at the bottom of the form)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Child/young person’s first name:** |  | | | | | **D.O.B:** |
|  |
| **Child/young persons surname:** |  | | | | | **Gender:** |
|  |
| **School Attendance:** |  | | | | | |
| **NHS Number** |  | | | | | |
| **Ethnicity** |  | | | | | |
| **Spoken language** |  | | | | | |
| **Is an interpreter needed?** (for Parent/Carer or child or young person) |  | | | | | |
| **Parent/carer’s names**  *Include forename(s) and surnames and please include all who hold parental responsibility where appropriate* |  | | | | | |
| **Home placement contact details** | ***Home telephone:*** | |  | | | |
| ***Mobile:*** | |  | | | |
| ***Address:*** | |  | | | |
| ***Email:*** | |  | | | |
| **School and Year** |  | | | **Year** |  | |
| **Head of House** |  | | | **Tutor** |  | |
| **Referrer Details** | ***Name*** |  | | | | |
| ***Email*** |  | | | | |
| ***Telephone*** |  | | | | |
| **Date of Referral *(dd/mm/yyyy)*** |  | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLA *(Child looked after)*** |  | | | | |
| **Details of social worker involved if applicable: (*Name and contact details)*** |  | | | | |
| **Is the Child/Young Person aware of the referral?** | **Yes** | | **No** | | |
| **Is this referral urgent? *Please tick yes or no. \*If urgent please use contact details at the bottom of the referral*** | **Yes** | | **No** | | |
| **Is the child a young carer? *Please tick yes or no*** | **Yes** | | **No** | | |
| **Medication Details**  *(e.g. name, dose, duration, side effects, prescriber)* |  | | | | |
| **Details of any professional reports attached** |  | | | | |
| **Context** | | | | | |
| ***Child in care*** |  | | | | |
| ***Child protection*** |  | | | | |
| ***Child in need*** |  | | | | |
| ***Early help family assessment*** |  | | | | |
| ***Adopted (if parents happy to share)*** |  | | | | |
| ***SEND*** |  | | | | |
| ***Pupil premium*** |  | | | | |
| **Insight** | | | | | |
| **Gillick Competency** | Assessed? | Yes  No | | Competent? | Yes  No |
| **Spoken to young person** |  | | | | |
| **Contacted parents/carers** |  | | | | |
| **Information shared about MHST/Getting Help website** |  | | | | |
| **GP involvement with referral** |  | | | | |
| **Previous Support** | | | | | |
| **None** |  | | | | |
| **Group/workshop** |  | | | | |
| **1:1/counselling** |  | | | | |
| **Nurture Group** |  | | | | |
| **ELSA support** |  | | | | |
| **Pastoral support** |  | | | | |
| **School nurse** |  | | | | |
| **Other** |  | | | | |
| **Please describe** |  | | | | |
| **Support Required** | | | | | |
| **Group/workshop** |  | | | | |
| **1 to 1 support** |  | | | | |
| **External agency** |  | | | | |
| **School nurse** |  | | | | |
| **Learning mentor** |  | | | | |
| **Counselling** |  | | | | |
| **Other (please specify)** |  | | | | |

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| --- | --- | --- |
| **Brief Summary of Referral** | | |
|  | | |
| **Previous MH History** | | |
| **Diagnosis or pending assessment?** | **CAMHS/EP/Other Clinician involvement?** | **Details of involvement, e.g. *who, when, why?*** |
| Diagnosis  Pending |  |  |
| Diagnosis  Pending |  |  |
| Diagnosis  Pending |  |  |
| Diagnosis  Pending |  |  |
| **What have you done already?** | | |
|  | | |
| **What’s not working so well? (E.g. self harm / suicidal thoughts / aggression or hostility/ neglect / bullied or bullying / alcohol or drug use)** | | |
|  | | |
| **Current Coping Strategies (if known)** | | |
|  | | |
| **Support Network** | | |
|  | | |
| **Desired Outcomes (Goals)** | | |
|  | | |

**Consent to share information with the MHST?**

**Yes**

**No**

**Parent/Carer Signature: ………………………………………………… Date: …………………….**

**Young person’s Signature: ………** **Date: …….**

**Referrer’s Signature: ………….** **Date: …………….**

**Requesters role/designation: ……………………………………………………………………...**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date**  **For EMHPS use only** | **Appendix 1 (pre-measure)** | | **Appendix 2 (post-measure)** | |
| **Date completed:** | | **Date completed:** | |
| **Baseline:** |  | **Review:** |  |

|  |
| --- |
| **CRISIS CONTACT** |
| If your child requires **Urgent** out of hours mental health support, please call our Urgent Helpline **0300 247 0000.** This phone line is open 24 hours a day, 7 days a week.  Your child should be taken to A&E (or call for an ambulance) if they require urgent medical attention that is life-threatening such as:   * Recent overdose (medication, harmful liquids etc) * Significant cuts (deep cut(s) and/or bleeding profusely) * Burns that are blistering/red * Loss of consciousness   Please remember that **999** is for life-threatening medical emergencies only. This is when someone is seriously ill or injured and their life is at risk.  Other sources of support available are ChildLine on 0800 1111, Samaritans on 116 123 |