**Referral Form**

**CAMHS Getting Help Team (GHT)**

**(Mental Health Support Only)**

**Please refer to the referrals checklist (last page)** for guidance when completing the referral form.

Once all areas of the referral form have been completed, please email the form to:

[**CAMHSGettingHelpEastReferrals@berkshire.nhs.uk**](mailto:CAMHSGettingHelpEastReferrals@berkshire.nhs.uk)

**Note: ALL** fields are required otherwise the referral will not be accepted

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| **Child/young person’s first name:**  **Child/young person’s surname:** | |  |  | | | | | | | | | **DOB:** | | | |  | |
|  | | | |  | |
|  | | | | | | | | | **Gender:** | | | | | |
|  |  | | | | | |
| **NHS Number** (if known): | |  |  | | | | | | | | |  | | | | | |
| **Ethnicity:** | |  |  | | | | | | | | |  | | | | | |
| **Spoken language:** | |  |  | | | | | | | | |  | | | | | |
| **Is an interpreter needed?** (for Parent/Carer or child or young person) | |  | **Yes** No  **NO** | | | | | | | | | | | | | | |
| **Preferred contact details for initial contact** *(name, relationship, telephone).* | |  |  | | | | | | | | |  | | | | | |
| **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 Address:*** | | | | | | | | |  | | | | | |
| **Young person’s contact details** *(REQUIRED If over the age of 16 years)* | |  |  | | | | | | | | |  | | | | | |
| **Present school/college/course details *(name):*** | | | | | | | | | | | **Year group** | | | | | |
|  | |  | | | | | | | | |  | | | | |  |
| **Head of year and form tutor names *(if possible):*** | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | |
| **Referrer Details:** | |  | ***Name*** | | |  | | | | | | | | | | |
|  | ***Job Role*** | | |  | | | | | | | | | | |
|  | ***Email*** | | |  | | | | | | | | | | |
|  | ***Telephone*** | | |  | | | | | | | | | | |
| **Date of Referral *(dd/mm/yyyy):*** | |  |  | | | | | | | | | | | | | |
| **CLA *(Child looked after):*** | |  | ***Yes*** | |  | | | | ***No*** | | | | |  | | |
| **Details of social worker involved if applicable: (*Name and contact details)*** | |  |  | | | | | | | | | | | | | |
| **Is the child/young person aware of the referral? *Please tick yes or no*** | |  | ***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)*** | |  |  | | | | | | | | | | | | | |
| **Have any supporting documents (professional reports / assessments) been attached to the referral?** | |  | **Yes** |  | | | | **No** | | | | |  | | | |
| **If yes, please specify which reports have been shared.** | |  |  | | | | | | | | | | | | | |
| **Please tick all that are appropriate** | ***Child in care*** | | | | | | | | | |  | | | | | |
| ***Child protection*** | | | | | | | | | |  | | | | | |
| ***Child in need*** | | | | | | | | | |  | | | | | |
| ***Early help family assessment*** | | | | | | | | | |  | | | | | |
| ***Adopted (if parents happy to share)*** | | | | | | | | | |  | | | | | |
| ***SEND*** | | | | | | | | | |  | | | | | |
| ***Pupil premium*** | | | | | | | | | |  | | | | | |
| **Gillick Competency** | | | | | | | | | |  | | | | | |
| **What has been actioned already?**  ***Please tick all that apply*** | **Spoken to young person** | | | | | | | | | |  | | | | | |
| **Contacted parents/carers** | | | | | | | | | |  | | | | | |
| **Information shared about MHST/Getting Help website** | | | | | | | | | |  | | | | | |
| **GP involvement with referral** | | | | | | | | | |  | | | | | |
| **What interventions/support have already been delivered?**  ***Please tick all that apply*** | **None** | | | | | | | | | |  | | | | | |
| **Group/workshop** | | | | | | | | | |  | | | | | |
| **1:1/counselling** | | | | | | | | | |  | | | | | |
| **Nurture Group** | | | | | | | | | |  | | | | | |
| **ELSA support** | | | | | | | | | |  | | | | | |
| **Pastoral support** | | | | | | | | | |  | | | | | |
| **School nurse** | | | | | | | | | |  | | | | | |
| **Other** | | | | | | | | | |  | | | | | |
| **If you have ticked any of the above, please provide details *e.g. dates, number of sessions and any other relevant information*** |  | | | | | | | | | | | | | | | |
| **If you have ticked ‘other’, please specify and give details here** |  | | | | | | | | | | | | | | | |
| **What do you want from the referral? *(Please check referral guidance and documents on what the GHT offer)*** | **Group/workshop** | | | | | | | | | |  | | | | | |
| **1 to 1 support** (for children over 12 years only) | | | | | | | | | |  | | | | | |
| **Support via parent/carer** | | | | | | | | | |  | | | | | |
| **Other (please specify below)** | | | | | | | | | |  | | | | | |
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| **Brief summary of reason for referral:**  (see checklist and guidance below to help you to complete this section) | |
|  | |
| **Desired Outcomes (Hopes and Goals)** | |
| ***Child/young person*** |  |
| ***Parent / Carer*** |  |
| ***Referrer*** |  |
| **Current coping strategies (if known)** | |
|  | |
| **What’s not working so well?** (E.g., self-harm / suicidal thoughts / aggression or hostility/ neglect / bullied or bullying / alcohol or drug use) | |
|  | |
| **Do you have concerns around risk of harm for this young person?** if yes please provide details and share what supports are in place | |
|  | |
| **Support network** (family, friends, other significant people, external agencies involved) | |
|  | |
| **Previous Mental Health History** | |
| |  |  |  | | --- | --- | --- | | **Diagnosis or pending assessment *(please specify)*** | **CAMHS/EP/clinician involvement *(Yes/No)*** | **Details of involvement *e.g. who, when, why*** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | |

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| **Consent to share:** | ***Yes*** |  | ***No*** |  |
| **Parent/Carer Signature:** |  | | **Date:** |  |
| **Young person’s Signature:** |  | | **Date:** |  |
| **Referrer’s Signature:** |  | | **Date:** |  |
| **Referrer Role/Designation:** |  | | | |

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

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| **CONTACT NUMBER** |  |  |
| **CAMHS Mental Health Support/Getting Help Team** | Opened 9am to 5pm | 0300 247 3002 |

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| **CRISIS CONTACT** | | |
| **Mental Health Access Team** | 24 hours | 0300 247 0000 |
| **NHS Direct** | 24 hours | 111 |
| **ChildLine** | 24 hours | 0800 1111 |
| **Samaritans** | 24 hours | 116 123 |
| **Mental Health, medical emergency or safety concerns** | 24 hours | 999 |

Guidance for completing the referral form:

**When completing the referral from please ensure you:**

* provide a clear overview of **mental health presentation** (e.g. low mood, anxiety, worries, (thoughts/feelings/behaviours), sleep, impact on day-to-day life, triggers à provide specific details on mental health).
* request the **staff member who knows the child/young person the best** to complete / contribute to the referral form (to allow for key information to be shared).
* **complete the form with the child/young person** or the parent, if possible, or at least ensure you have gathered their views. Ensure they have given consent to make the referral.
* note what are child / young person or parent/carer **goals / hopes** from accessing support are
* detail **previous support** accessed by the child/young person/family (e.g. provide details of what worked well / not so well)
* detail **current supports** in place or pending referrals (e.g., counselling, other CAMHS)
* **read what the GHT offers in terms of interventions**. The team provide low level mental health intervention for the child/young person and/or parent/carer. Please clarify how you think this would meet their mental health needs
* consider the needs and **level of complexity**, i.e. is this more suitable for consultation (support for Early Help/Social Services staff that the GHT can offer) rather than direct work with the child/young person and/or parent/carer?