**Professional / Parent Referral Form**

**for Kingston & Richmond Child and Adolescent Mental Health Services Single Point of Access (CAMHS SPA)**

Please complete and send this referral form and any attachments by secure email to krcamhsreferrals@swlstg.nhs.uk

**Please be aware we are not an emergency service and should the child / young person require** **immediate medical care please taken them to the nearest A&E. Alternatively, please see our crisis information sheet (available on our website) for websites and phone numbers where you can seek additional support.**

*For additional referral queries, the K&R CAMHS SPA team can be contacted on 020 3513 4499 (Mon-Fri 9am-5pm) or via email* *camhsspaadmin@swlstg.nhs.uk*

Please note that this form is for referrals for new patients only. If you are wanting to raise concerns about a child already open to CAMHS, please contact the relevant service directly.

If you wish to refer a child for concerns of an eating disorder, you can refer directly to the specialist CAMHS Eating Disorders Service. Their referral form is available on their website: [Children and Young Person’s community eating disorders service (CYP CEDS) (swlstg.nhs.uk)](https://swlstg.nhs.uk/service-detail/service/children-and-young-peoples-community-eating-disorders-service-70/)

Please complete as much information as you can, as it helps us to safely triage.

|  |
| --- |
| **Referrer’s Details** |
| **Name** |  | **Job Title / Relationship to child** |  |
| **Organisation** |  |
| **Address**  |  |
| **Tel** |  | **email**  |  |
| **Alternative contact person and contact details**  |
|  |
|  |
| **Consent**  |
| **E-signature / print name of Referrer:** |  | **Date**:  |  |
| **Who has consented to the referral?**  | [ ]  Parent / carer[ ]  Young person ***(if 16 or 17 young person’s consent must be sought)*** |
| **Does the YP (if over 16) or parent / carer (if under 16) consent for school to be made aware of the referral?** | Yes | No |
| [ ]  | [ ]  |
| **Please note here if either parent/carer (with Parental Responsibility) is not informed of this referral and give reasons why:** |
|  |
| *In signing this form on behalf of the parent or guardian, you are confirming that consent is given for South West London and St George’s Mental Health Trust – Kingston & Richmond CAMHS to share the referral information as outlined in this document with other agencies as appropriate for safeguarding purposes or to signpost to other NHS services or other services within the local emotional health service provision.* |
|  |
| **Overall Level of Concern**  |
| Routine | Moderate | High |
| [ ]  | [ ]  | [ ]  |
| Why? |  |
|   |
| **Child’s Details** |
| First name  |  | Surname |  |
| NHS number *if known* |  | Sex (at birth): |
| DOB |  | Age |  | Male | [ ]  |
| Female | [ ]  |
| Gender Identity: Does their current gender identity match their sex at birth? |
| Yes | No | Unknown | If no, please give details, including preferred pronouns: |
| [ ]  | [ ]  | [ ]  |  |
| Home Address |  |
| Postcode |  |
| Tel number(state whose) |  |
| Alternative number (state whose) |  |
| Tel number of child **if over 16** |  |
| Parent/carer’s email  |  | Unknown | [ ]  |
| Child’s email  |  | Unknown | [ ]  |
| **Ethnicity** *if known / if possible to disclose*  | *(select from list)* Select | Unknown | [ ]  |
| If other ethnicity, *please enter* |  |
| If English is **not** the main Language spoken - what is the family’s main language? |
|  | *Is an Interpreter required?* |
| Yes | No |
| [ ]  | [ ]  |
| Are there are any other communication barriers for the family?  |
| Yes | No | Unknown | If yes, please give details: |
| [ ]  | [ ]  | [ ]  |  |
| **Disability** **or Health Condition,** *if possible, to disclose*  |
| Yes | No | Unknown | Is yes, please give details: |
| [ ]  | [ ]  | [ ]  |  |
|  |
| **School / College name**  |
| *(completing this helps us identify whether they have access to a CAMHS school service)* |
|  |
| Is there a preferred named contact within school? |
|  |
|  |
| **Parent or Guardian details**  |
| Are parents aware of referral? |
| Yes | No | If no, please explain | N/a – Parent referral |
| [ ]  | [ ]  |  | [ ]  |
|  |
| Does the child have a parent/carer who is an ex-member of the British Armed Forces  |
| Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
|  |
| **Parent / Family Members**  |
| *as known (please indicate parents/carers with parental responsibility, by marking ‘PR’ next to their relationship to the child, including parents residing at other addresses. If referring a child looked-after, please give details of both the parents and current carers as appropriate).* |
| Family member(s) within the same address |
| First name | Surname | Relationship to Child (note if has ‘PR’) | Date of Birth / Age |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Parent (s) / guardian (s) with parental responsibility at different address  |
| Address  |  | Tel Number  |  |
| First name | Surname | Relationship to Child (note if has ‘PR’) | Date of Birth / Age |
|  |  |  |  |
|  |  |  |  |
| **GP Details****Please note: certain CAMHS services (neurodevelopmental assessments or psychiatry / Tier 3 CAMHS) are determined by the location of a child’s GP. If the child does not have a Kingston or Richmond GP we may be unable to accept the referral. If this is the case we will contact the referrer & family with advice.**  |
| Name of GP |  |
| Practice name |  |
| Address  |  |
| Tel |  | Email |  |
|  |
| **Current Professional Involvement:**  |
| Has EHCP (Education & Health Care Plan) | Yes | No | Applied | Unknown |
| [ ]  | [ ]  | [ ]  | [ ]  |
| Special Education Needs | Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
| Receives SEN support | Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
| Looked After Child?  | Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
| If yes, please give legal status (and known dates):  |  | Unknown |
| [ ]  |
| Child Protection or Safeguarding concerns?  | Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
| If yes, give details |  |
| Open to Social Care  | [ ]  | Child in Need Plan  | [ ]  | Child Protection Plan | [ ]  |
|  |
| **Professions currently involved** |
| *If known: Social Worker, Family Support Worker, Mental Health Support Team in School, Health Professionals, other involved professionals with the child and/or family*  |
| Name of Professional | Organisation | Phone number | Email address | Permission to contact?  |
|  |  |  |  | Y / N  |
|  |  |  |  | Y / N |
|  |  |  |  | Y / N  |
|  |  |  |  | Y / N |
|  |
| Have you also made a referral to other services alongside this CAMHS referral? |
| Yes | No | If yes, please state which other service you have referred to: |
| [ ]  | [ ]  |  |
| Has child had contact with CAMHS in the past? |
| Yes | No | Unknown | If yes, please give details |
| [ ]  | [ ]  | [ ]  |  |
| Please list any supportive interventions that have already been attempted, by who, and attach relevant reports. (e.g., parenting, early help, counselling, private support, etc)If previously had an assessment or therapy (NHS or private) please **attach reports/clinic letters.** Please include details of relevant medications prescribed. For example:  |
| Please give details:  |
|  |
| **Presenting problem or issue**  |
| *Please describe the problems the young person is having and why you think a CAMHS assessment is needed. Please include as much detail as you can.* *Tell us when the symptoms started, how long they last, how often they happen and how severe they are.* *Neurodevelopmental disorders (like ASC or ADHD) and other mental health difficulties are seen across settings – home, school, and community, therefore please give as much detail as possible in relation to different settings.* |
|  |
|  |
| **Impact of problem on the child and family** |
| *Please describe the effect of the current difficulties on the child & family (such as the child’s development, family life, social life, learning / academic performance) – include as much detail as possible* |
|  |
|  |
| **Other sources of stress facing the child and family** |
| *Please outline any other sources of stress the child & family may be facing that may be affecting their wellbeing – include as much detail as possible* |
|  |
|  |
| **Protective factors / strengths that may be supporting the child and family** |
| *e.g. what positive things are going on for the young person or are there people that are supporting the family / young person? — include as much detail as possible* |
|  |
|  |
| **Risk factors** |
| **Do you have concerns that the child is at risk to self or others?**  |
| Yes | No | **If yes, please answer the questions below:** |
| [ ]  | [ ]  | If yes, what risk concerns do you have?  |
|  |
| Are there are any protective factors?  |
|  |
| If yes, do you consider the level of risk to be (see guidance): |
| Low | Medium | High |
| [ ]  | [ ]  | [ ]  |
| ***Guidance:***  |
| *Low; e.g.:* * *no suicidal plan or intent,*
* *low level self harm but overall feels safe,*
* *low risk of harm to others.*
 | *Medium; e.g.:* * *Frequent or more intense self-harm,*
* *suicidal ideas,*
* *but no imminent plan,*
* *may pose some direct threat to others*
 | *High; e.g.:** *Daily or deep self-harm over vulnerable areas,*
* *suicidal ideas with plan and intent,*
* *does not feel safe,*
* *there is significant risk to others,*
* *command hallucinations of harm to others*
 |
| **We would request that for any professionals making a referral if they consider the risk to be Medium or High – please ensure that any risk has been shared with a parent /carer** |
| **Have you advised the child and / or family on how to keep themselves safe and/or given safety advice?**  |
| Yes | No | If yes, please give details of what advice you have given about how to keep the young person safe?  | N/a – Parent referralPlease see the advice & resources handouts on our website |
| [ ]  | [ ]  |  | [ ]  |
| [ ]  | Crisis numbers | [ ]  | A&E advice |
| [ ]  | Advice around reducing the risk of harm | [ ]  | Leaflets / information given |
| [ ]  | Other: please give details below: | [ ]  | Websites / apps |
|  |  |
| Please direct the young person/ family to the crisis and safety information on our CAMHS SPA website:  |
|  |
| What do parents expect from this referral? |  |
| What does the child/ young person expect from this referral? |  |
| What do you as the referrer expect from this referral? |  |