**16 / 17 year old Self-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 you require immediate medical care please go 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 young people not already open to CAMHS. If you are already open to CAMHS, please contact that relevant service directly.

If you wish to refer yourself 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.

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| --- |
| **Consent** |
| **Your E-Signature :**  |  | Date |  |
| **Do you consent for school to be made aware of the referral?** | Yes | No |
| [ ]  | [ ]  |
| *In signing this form 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.* |
|  |
| **Your Details** |
| First name  |  | Surname |  |
| NHS number *if known* |  | Sex (at birth): |
| DOB |  | Age |  | Male | [ ]  |
| Female | [ ]  |
| Gender Identity: Does your current gender identity match your sex at birth? |
| Yes | No | Unknown | If no, please give details, including preferred pronouns: |
| [ ]  | [ ]  | [ ]  |  |
| Address |  |
| Postcode |  |
| Your Tel number  |  |
| Alternative number  |  | Please state whose *mother / father / other?* |  |
| Your email  |  |
| Parent/carer’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 your family’s main language? |
|  | *Is an Interpreter required?* |
| Yes | No |
| [ ]  | [ ]  |
| **Disability** **or Health Condition,** *if possible, to disclose*  |
| Yes | No | Unknown | Please give details: |
| [ ]  | [ ]  | [ ]  |  |
| Do you have an EHCP (Education & Health Care Plan) | Yes | No | Applied | Unknown |
| [ ]  | [ ]  | [ ]  | [ ]  |
| Do you have any Special Education Needs | Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
| Do you receive SEN support | Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
|  |
| Do you have a parent/carer who is an ex-member of the British Armed Forces  |
| Yes | No | Unknown |
| [ ]  | [ ]  | [ ]  |
|  |
| **School / College name**  |
| *(completing this helps us identify whether you have access to a CAMHS school service)* |
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| Is there a preferred named contact within school? |
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| **GP Details****Please note: certain CAMHS services (neurodevelopmental assessments or psychiatry) are determined by the location your GP. If you do not have a Kingston or Richmond GP we may be unable to accept your referral. If this is the case we will contact you with advice.** |
| Name of GP |  |
| Practice name |  |
| Address  |  |
| Tel |  | email |  |
|  |
| **Parent / Family Members**  |
| Family member(s) living at the same address as you |
| First name | Surname | Relationship to you  | Date of Birth / Age |
|  |  |  |  |
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| Parent (s) / guardian (s) living at a different address  |
| Address  |  | Tel Number  |  |
| First name | Surname | Relationship to you  | Date of Birth / Age |
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| **What are your main concerns?**  |
| *Please describe your current concerns and what support you are looking for** *Include as much detail as possible*
* *How long have these concerns been present for you?*
* *Were there any events before that might have led to the start of these concerns?*
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| **How has this affected your life/family/friends?** |
| *For example – you can describe the effect your difficulties have had on your relationships with others, general health, school or on your ability to do activities etc.* |
|  |
| How much of an impact have these issues had on your general wellbeing? |
| A huge impact | It’s affecting me  | I’m not too worried  | I’m not sure  |
| [ ]  | [ ]  | [ ]  | [ ]  |
|  |
| **Other sources of stress you may be facing?**  |
| *For example – you can include details on any losses, separations, relationship difficulties or family history of health issues* |
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|  |
| **Helpful things / strengths that may be supporting you** |
| *What or who helps support you? What are your strengths?*  |
|  |
|  |
| **Risk concerns** |
| **Have you ever harmed yourself?**  |
| Yes, in the past | Yes, currently | No, never | I’ve thought of it |
| [ ]  | [ ]  | [ ]  | [ ]  |
| **Have you ever had thoughts of ending your life?** |
| Yes, in the past | Yes, currently | No, never |
| [ ]  | [ ]  | [ ]  |
|  |
| **People Aware of Referral** |
| Is anyone aware of this referral? |
| Yes | No | *If yes, please specify their relationship to you (i.e.: friend, mother, etc.) and name* |
| [ ]  | [ ]  |  |
| Is anyone aware of your concerns? |
| Yes | No | *If yes, please specify their relationship to you (i.e.: friend, mother, etc.), their name and their contact details if you are alright with us contacting them* |
| [ ]  | [ ]  |  |
| Are your parent(s) / guardian(s) aware of your concerns? |
| Yes | No | *If no, you can explain here why they do not know about your concerns* |
| [ ]  | [ ]  |  |
| Are you happy for us to discuss this referral with your parents(s) / guardian(s)?  |  |
| ***Please note that if we feel you’d benefit from a CAMHS Service, that service may require you to bring either a parent or appropriate adult along to your first appointment. If the difficulties in this referral highlight any concerns regarding your safety, please be aware that we will have to inform your parent or carer in order that they can support us to keep you safe. If you have concerns about any of the above, please let us know in this referral and we will call you to discuss further.*** |
| **Is anyone helping or supporting you at the moment?**If yes, please tell us who or which organisations. Please provide contact details.  |
| Name of Professional | Organisation | Phone number | Email address |
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| **Any interventions/supports that have already been attempted and by whom***(for example - you can put down any support/intervention you have received and describe the usefulness of said support/intervention)* |
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| **Have you had a social worker?** |
| Yes, in the past | Yes, currently | No |
| [ ]  | [ ]  | [ ]  |
| **Do you have any concerns regarding your safety or the safety of others?***If yes, please explain* |
|  |