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| **CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) Argyll & Bute****REFERRAL FORM** (effective from 05/10/22) | HI_blk |

Please complete all \* fields below. It is essential that the questions are answered appropriately to allow the CAMHS team to proceed with any referral.

Any incomplete \*required questions will lead to the referral being returned to the sender and may result in a delay for the young person potentially accessing our service.

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| **\*NAME OF YOUNG PERSON:** |  |
| **\*ADDRESS OF YOUNG PERSON:** |  |
| **\*CONTACT DETAILS OF YOUNG PERSON:Home phoneMobile (parent/carer or young person)Email (parent/carer or young person)** |  |
| **\*DATE OF BIRTH OF YOUNG PERSON** *(or CHI if known):* |  |
| **YOUNG PERSON’S REGISTERED GP’S NAME AND SURGERY:** |  |
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| **\*A copy of this form MUST be sent to the registered GP by the referrer. Has a copy been sent?** | Yes | No |
| **\*Have you seen/spoken to the young person directly?** | Yes | No |
| **\*Has the young person consented to the referral?** | Yes | No |
| **Have the young person’s parents/carers consented to the referral?** | Yes | No |

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| **\*Overview of Mental Health Concerns** *(i.e. significant self-harm, anxiety, low mood etc.)* |
| **Presenting issues?** *(please include any details of symptoms, time of onset, duration, frequency, intensity and environmental triggers, whether these have persisted over time and their combined impact on functioning.)* |
| **How does the concern affect the young person’s home, school and social life? (Please pay particular note to impact on functioning)** |
| **Duration (when did this concern begin?)** |
| **Previous interventions and outcomes: (see referral criteria for specific Tiers)****With whom?****When?****What was tried?** |
| **Brief/Relevant Medical History (and any relevant family medical/ mental health history)****Current medication (please also note any known medication sensitivities/allergies)** |
| **If referral relates to a suspected eating disorder:Physical health data: HR, BP, Height, Weight, BMI, date and results of any recent investigations.** |
| **What does the young person and family and referrer (please state) hope to gain from CAMHS involvement? (please include details of what the young person themselves and their support network would like from CAMHS intervention) And any other information the young person or family wish to share?** |

*There may be circumstances when a young person under the age of 16 does not wish their parents to know about referral to CAMHS.*  *If this is the case then please also state the reason as this will aid with progressing the referral.*

**PLEASE COMPLETE ALL SECTIONS AS FULLY AS POSSIBLE**

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| **If older than 16, staying at school?**  |  **Yes / No** |
| **Is the child/young person care experienced? Yes / No****(if Yes, please enclose Child’s Plan and Chronology)****Social Worker Name & Contact Details:** **Current Placement Details & Legal Status** (e.g. Foster Care, Residential Care, Kinship Care, Adoption, Compulsory Supervision at Home; Temporary or Permanent placement) **Date placement commenced**:  |
| **Pre-existing diagnoses?** (e.g. Learning disability / autism spectrum disorder / attention deficit hyperactivity disorder/etc - *please confirm diagnosis below)* |

Are there any special requirements for appointments e.g. wheelchair access, interpreter Y/N

If YES please specify:

**OTHER AGENCIES**

**What other agencies are currently involved or has the young person been referred to**

*(i.e. GP, social worker, school, paediatrics etc.)***?**

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| **Agency** | **Involved****or****Referred?**(state I or R) | **Name** | **Address** | **Telephone** |
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**RISK FACTORS** *(please do not leave blank)*

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| **Type of harm** e.g. any harm to self or others (including relevant familial risks) any risk from others, self-neglect, any substance abuse, any offending behaviour or other**:** *(If no risks are identified please state this explicitly)***:** |
| **Have parents/carers been informed of risks? Yes / No** |
| **Has a safe plan been put in place? Yes / No** |
| **What was agreed?** |
| **Is there a Child Protection Plan in place? Yes / No Registration Category:** |

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| **Name of person completing this form:** |  |
| **Designation:** |  |
| **Signature:***(Have ALL Required sections been completed?)* |  | **Date:**  |
| **Work address:****Email:****Contact Tel No:** |

**ALL referrals to CAMHS Argyll & Bute should be sent to either:**

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| **COWAL & BUTE** | **OLI & MAKI (Lochgilphead)** | **HELENSBURGH & LOCHSIDE** |
| Child & Adolescent Mental Health Services (CAMHS)Cowal Community Hospital360 Argyll StDunoonArgyll & Bute PA23 7RLTel: 01369 708718nhsh.cb.camhs@nhs.scot | Child & Adolescent Mental Health Services (CAMHS)Aros CottageArgyll & Bute HospitalLochgilpheadArgyll & Bute PA31 8LDTel: 01546 606082nhsh.camhs-aros@nhs.scot | Child & Adolescent Mental Health Services (CAMHS)Lomond House29 Lomond StHelensburghArgyll & Bute G84 7PWTel: 01436 633200nhsh.camhs-hvicc@nhs.scot |

All referrals should be sent to CAMHS Argyll & Bute using this referral form.

CAMHS is open between 9am and 5pm, 5 days a week and can provide advice and information regarding which referrals are appropriate, as well as the services provided by Specialist CAMHS and details regarding the type of information to highlight if there are concerns about a child or young person.

If there are concerns regarding a child or young person who might need an urgent mental health assessment they should be advised to see their GP.

**Completing the form**

To make a referral to CAMHS it is essential to supply the information detailed in the referral form.

The referral form is aimed to be a guide with a view to it being completed by the referrer and the parent/carer/young person together. It is essential that we receive good quality information to help us to assess the urgency and suitability of service.