Barnsley Child and Adolescent Mental Health Service (CAMHS) Referral Form

Barnsley C.A.M.H.S see Children & Young People with severe, complex or persistent mental health difficulties

Please refer to Barnsley CAMHS Referral Guidance document for further information

Please post to: Child and Adolescent Unit, New Street Health Centre, Upper New Street, Barnsley, S70 1LP

Ring: 01226 644829 *to discuss a referral with the Duty Worker* **Fax to:** 01226 433194 if urgent

Email to: barnsleycamhs.referrals@nhs.net (emailed referrals **must** be via secure email i.e. NHS.net, GCSX, pnn.police.uk)

About the Young Person

Name:

Also known as:

Date of Birth:

NHS Number:

☐ **Male** ☐ **Female**

Ethnicity:

First Language:

Interpreter required: ☐ **Yes** ☐ **No**

Asylum Seeker: ☐ **Yes** ☐ **No**

Home Address:

Postcode:

Method of contact:
Post ☐ **Telephone** ☐ **Mobile** ☐

Postal Address (if different):

Postcode:

Telephone:

Mobile:

Parent / Carers names **Relationship**

School / College:

Person to contact:

GP Name:

GP Address:

GP Post Code:

About the Referrer

Name:

Job Title:

Agency:

Address:

Postcode:

Telephone:

Email:

Signature:

Date of referral:

Has the young person consented to this referral?
☐ **Yes** ☐ **No**

Has the parent/carer consented to this referral?
☐ **Yes** ☐ **No**

Other people / agencies involved:

Is an Early Help Assessment in place? ☐ **Yes** ☐ **No**
If so please attach latest copy and name of lead professional:

Is a Child In Need plan in place? ☐ **Yes** ☐ **No**
If so please attach latest copy and name of lead worker:

Is there a Child Protection Plan? ☐ **Yes** ☐ **No**
If so please attach latest copy and name of lead worker:

Past CAMHS involvement: ☐ **Yes** ☐ **No**

Date child/young person last seen:

Is the young person in the care of the Local Authority?
☐ **Yes** ☐ **No**
If yes, please give name of Local Authority responsible for providing care:

Name of Social Worker:

Please circle as appropriate

Is the client attending school?	**Yes**	**No**	**Sometimes**
Do they have positive friendships?	**Yes**	**No**	**Sometimes**
Do they settle and sleep in their own bed?	**Yes**	**No**	**Sometimes**
Do they keep themself safe from harm?	**Yes**	**No**	**Sometimes**
Do they participate in social activities?	**Yes**	**No**	**Sometimes**
Do they eat regularly throughout the day?	**Yes**	**No**	**Sometimes**

Referrers concerns and aims :

Details of mental health difficulties and how these are affecting the child / young person, current situation, relevant background information, what has been tried etc. (Please attach any further information as necessary)

Young Person's concerns and aims (if different)

Can they talk about how they feel? If so who to?

Parent / Carer concerns and aims (if different)

Have other support/self-help methods been applied prior to this referral?

Special Needs and Risk Factors

Does the child/young person have:

Learning disability: Mild ☐ Moderate ☐ Severe ☐ None ☐	**Poor mobility:** Mild ☐ Moderate ☐ Severe ☐ None ☐
Literacy problems: Mild ☐ Moderate ☐ Severe ☐ None ☐	**Sensory impairment:** Mild ☐ Moderate ☐ Severe ☐ None ☐
Other disability / special need – Please specify	
Child Health issues: ☐ Yes ☐ No	**Educational Breakdown:** ☐ Yes ☐ No
Family Health issues: ☐ Yes ☐ No	**Housing issues:** ☐ Yes ☐ No
Parental agoraphobia: ☐ Yes ☐ No	**Parental Separation:** ☐ Yes ☐ No
Parenting Issues : ☐ Yes ☐ No	**Risk of violence / Domestic Abuse:** ☐ Yes ☐ No
Substance Misuse Issues: ☐ Yes ☐ No Alcohol ☐ Drugs ☐	**Youth Offending issues:** ☐ Yes ☐ No Please attach appropriate details (contact name, report, etc.)
Other risk factor – Please specify	

NB: ***Below is for CAMHS Internal use only***

Presenting Problem

Adjustment to health issues		Drug and alcohol difficulties		Obsessive compulsive disorder		Relationship difficulties	
Anxiety		Eating disorders		Organic brain disorder		Attachment difficulties	
Conduct disorders		In Crisis		Phobias		Self-harm behaviours	
Depression		Neurodevelopment conditions		Post-traumatic stress disorder		Unexplained physical symptoms	

Additional or Other - Please specify (Bi Polar / Other Psychosis / Emerging Personality Disorders / Gender Discomfort issues)

Office Use:						
Date Received:		**Date read at allocation:**				
People reading at allocation:						
Outcome at allocation:	Urgent : Passed to Duty Worker ☐	Choice ☐	Consultation Clinic ☐			
	Discuss at Team Meeting ☐	Other ☐	Not accepted ☐			