South West Yorkshire Partnership NHS
NHS Foundation Trust

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 644819 *to discuss a referral with the Duty Worker* **Fax to:** 01226 280897 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**

If your referral is query an **eating disorder** Height and Weight needs taking at the GP Surgery and recording here with the date taken.
Please state any previous height and weight recordings and date taken:

GP Name:

GP Address:

GP Post Code:

About the Referrer

Name:

Job Title:

Agency:

Address:

Postcode:

Telephone:

Email:

Signature:

Date of referral:

Date child / young person last seen by referrer:

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**

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:

This sheet must be completed for the referral to be accepted for triage by CAMHS. This is to ensure our policy around confidentiality and information sharing is adhered to. This also allows for more timely and thorough assessment of referral information.

Has the young person consented to this referral?	**Yes**	**No**
Has the parent/carer consented to this referral?	**Yes**	**No**
If the young person is under 16 and has been seen alone or without parent / carers knowledge of the referral can you confirm that you have assessed that they are Gillick Competent	**Yes**	**No**

If you have ticked no then we cannot accept this referral unless parent / carers have been informed

Does the young person or Parent / Carer give consent for Barnsley CAMHS to contact other services involved with their care (this would be to gather more information in relation to the referral)	**Yes**	**No**

Are there any services which the Young Person or Parent / Carer does not give consent for Barnsley CAMHS to contact. Please state below

Parental Responsibility

Please detail who holds parental responsibility for the Child / Young Person

Other agencies involved Eg Social Worker, Family Support, OT

Name	Contact Details	Nature of Involvement

School / College Details

Name of school / college	Main Contact	Is the child / young person attending

PTO

Referrers concerns and aims :

Details of mental health difficulties and how these are affecting the child / young person at home and school. If you feel the referral is query for ASD Diagnosis please contact the ASDAT Service on 01226 644869.

Previous Medical History

Significant Life Events

What does the young person want from this referral?

What does the Parent / Carer want from this referral?

Have other support/self-help methods been applied prior to this referral eg Parenting courses, other therapies

PTO

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 / formal diagnosis

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.)

If you have ticked yes to any of the above please give details:

Other risk factor eg Self harm, CSE, Violent behaviour– Please specify and give details below:

With **all of us** in mind.