Mental Health Support Team Referral Form

All mandatory fields marked with an **

Please tick to confirm if this referral has been discussed anonymously with a member of MHST staff ☐ **If so, name of practitioner:**	**Has this child been discussed for group work?** ☐ Yes ☐ No ☐ Unknown **If yes, please provide more information:**

Consent: *Referrals will not be processed unless all consent is sought and ticked, unless consent not needed from parental responsibility, as outlined below:*

** **Has the person with parental responsibility consented to this referral?**
N.B. if the young person is competent according to Fraser guidelines they can consent to the referral without permission from the person with parental responsibility
☐ Yes ☐ No ☐ No consent needed (as outlined above)

** **If yes, has the person with parental responsibility consented to sharing the information in this form with the MHST and to liaise with relevant agencies if required?**
☐ Yes ☐ No ☐ No consent needed (as outlined above)

** **Has the child/young person consented to this referral?**
☐ Yes ☐ No ☐ Isn't needed due to young age

** **If yes, has the child/young person consented to sharing the information in this referral form with the MHST and to liaise with relevant agencies if required??**
☐ Yes ☐ No ☐ Isn't needed due to young age

By consenting to this referral, please note that, upon screening, it may be appropriate for your referral to be passed to another team within the wider CAMHS Service.

** **Young person's consent to be contacted via:** (please tick all that apply)
☐ Phone ☐ Email ☐ Voicemail
☐ Text ☐ Post ☐ None

** **The person with parental responsibility's consent to be contacted via:** (please tick all that apply)
☐ Phone ☐ Email ☐ voicemail
☐ Text ☐ Post

Details of child/young person:

** **Legal First name(s):**	** **Date of birth:**
** **Legal Surname:**	**NHS number:**
Previous names:	** **First language:**
Preferred name:	**Nationality:**
** **Gender/Sex:** ☐ Male ☐ Female **Sexual orientation:** ☐ Heterosexual/straight ☐ Lesbian/Gay ☐ Bisexual	** **Address:** ** **Postcode:** ** **Geographical area/district:**

☐ Prefer not to say ☐ N/A (Not Fraser Competent) ☐ Other: _____	**Contact number for young person if over 13yrs:** ** **Email address for young person if over 13yrs:**
** **School/college:**	**Is the child/young person in receipt of Pupil Premium?** ☐ Yes ☐ No
** **Year group:**	** **School attendance:** _____ %

Religion/Belief:

☐ Atheism ☐ Sikhism ☐ Buddhism ☐ Judaism ☐Christianity ☐ Hinduism ☐ Islam ☐ Jainism

☐ Other (please state)_____ ☐ Do not wish to say

** **Ethnic category:** *Mandatory for completion*

White
- ☐ British
- ☐ Irish
- ☐ Any other white background

Mixed
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background

Asian or British Asian
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Any other Asian background

Black or Black British
- ☐ Black African
- ☐ Black Caribbean
- ☐ Any other Black background

Other Ethnic Groups
- ☐ Chinese
- ☐ Any other Ethic Group
- ☐ Not stated

- ☐ Not known
- ☐ Other: _____

Details of GP:

** **Name of GP practice:**	**Address:** **Contact number:**
Existing Physical Health Conditions:	

Details of parent/carer:

** **Parent/carer's full name and relationship to child/young person:**

** **Does this person have legal responsibility for the child/young person?** ☐ Yes ☐ No

** **Contact number:**

** **Email address:**

Address (if different from child/young person's):

** **Is this the child's emergency contact?** ☐ Yes

☐ No, their emergency contact is:

_____ *(name)* _____ *(number)* _____*(relationship)*

Second parent/carer's full name and relationship to child/young person:

Contact number:

Email address:

** **Do we have permission from the young person to liaise with the parent/carer regarding this referral if required?** ☐ Yes ☐ No N/A as child under 13yrs ☐

If no, what is their contact preference if YP does not want any adults involved and competency is agreed?

** **Details: Please tell us why the child/young person would benefit from our service?**
Please put as much detail as possible to enable us to triage appropriately and avoid delay in helping your YP by needing extra information. Please also include details of the pre-referral conversation.

** **What are the key presenting issues?**

☐ Anxiety ☐ Behaviour difficulties ☐ OCD ☐ Social Anxiety ☐ PTSD
☐ Phobia ☐ Worry ☐ Low mood ☐ Other _____

Who is currently involved with the child /YP? (Please include approximate start date and type of support)

Has this child/YP ever talked to another "professional" about their problem(s)? ☐ Yes ☐ No ☐ Unknown

If yes, please describe who this was below (Examples include teacher, social worker, nurse, doctor, youth worker, CAMHS worker, family service worker or other professional)? Please include approximate dates and outcome of external agency intervention, where possible.

** **What are the current mental health concerns and how are they impacting the child's/YP's everyday life?** (Consider effects on home life, school life, social life, sleep, eating etc)

** **When did these difficulties start? Has anything happened that lead to things becoming worse?**

** **What current support/reasonable adjustments are in place to support the child/YP?**

** **What is going well for the YP at present? Any strengths, interests, or protective factor?**

** **Why have you decided to ask for support now?**

Safeguarding / Child Protection details:

**** Is the child/young person on a Child Protection Plan?**

☐ Yes ☐ No ☐ Unknown

**** Has the child/young person been on a Child Protection Plan in the past?**

☐ Yes ☐ No ☐ Unknown

**** Is the child/ young person 'looked after' (e.g. fostered) by the Local Authority?**

☐ Yes ☐ No ☐ Unknown

****Are there any past or current concerns regarding suicidal thoughts, self-harm, harm to others or harm from others?** Please provide known triggers, method of self-harm, frequency, date of most recent occurrence and action taken.

****Are there any other safeguarding concerns?** (e.g. family or relationship problems) Please provide details of the concerns, dates, actions taken (eg. MASH referral submitted), and outcome.

Has this YP ever had a named social worker?

Requirements:

**** Do the family require a interpreter?**	☐ Yes	☐ No	☐ Unknown
If so, please state language required	_____		
**** Does the child/young person have Special Educational Needs?**	☐ Yes	☐ No	☐ Unknown
If so, please state	_____		
Are there any SEN under investigation?	☐ Yes	☐ No	☐ Unknown
If so, please provide approximation date of documentation submitted	_____		
**** Does the child/young person have an Educational Health Care Plan (EHCP)?**	☐ Yes	☐ No	☐ Unknown
**** Does the child/young person have medical needs?**	☐ Yes	☐ No	☐ Unknown
If so, please state	_____		
**** Does the child/young person have any accessibility needs?**	☐ Yes	☐ No	☐ Unknown
If so, please state	_____		
**** Does the parent/carer have any accessibility needs?**	☐ Yes	☐ No	☐ Unknown
If so, please state	_____		
**** Is the child/young person a 'young carer'?**	☐ Yes	☐ No	☐ Unknown
**** British Armed Forces Indicator Is the child/young person a dependant of an ex-serving member?**	☐ Yes	☐ No	☐ Unknown

**Are there any other requirements that we need to be aware of?	☐ Yes	☐ No	☐ Unknown
_____			

Referrer details	
** Referrer name and job title:	** Referrer email address:
** Referrer contact number:	** Date of referral:
** Member of school staff to contact if further information is required, (if different from above). Name: _____ Email: _____	
** Member of school staff member to contact to make an appointment Name: _____ Email: _____	
** Member of school staff member to contact to make a Microsoft Teams appointment Name: _____ Email: _____	

Please send completed forms to:	**School Mental Health Lead to forward completed forms to:** **CAMHS SPA:** SPAReferrals@nottshc.nhs.uk Please indicate in the email subject that the referral is for the Mental Health Support Team **Contact number for SPA:** 0115 8542299	**Mental Health Support Team** CAMHS Integrated Specialist Services Nottinghamshire Healthcare NHS Foundation Trust Underwood House Highbury Hospital Nottingham NG6 9DR **MHST:** 0115 8760167 **Email:** CAMHSMHSTReferralCo-ordinators@nottshc.nhs.uk **(For queries only)** **Or** CAMHSMHSTTrailblazer1@nottshc.nhs.uk **(For queries only)**
	****Please be aware that incomplete referrals will not be processed and will cause a delay in the child/young person receiving support.**	
	If you would like to include any parental views, please do so on a separate sheet and attach to this form.	