

**Children & Young People’s Service, Single Point of Access, Hampshire**

Email completed referrals to [**SPNT.HantsCamhsSpa@nhs.net**](mailto:SPNT.HantsCamhsSpa@nhs.net) **- Consultation line - Call 0300 304 0050**

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| **Hampshire Specialist CAMHS Referral (*please refer to Section 8 for referral criteria*)** |

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| Name of CAMHS Clinician, if referral is taken over the phone: | | | | | | | |
| **SECTION ONE – YOUNG PERSON DETAILS** | | | | | | | |
| **Forename** |  | | | | | **Surname** |  |
| **Also known as** |  | | | | | **Date of Birth** |  |
| **Gender** |  | | | | | **NHS No.** |  |
| **Address at which the child/young person is currently living** |  | | | | | | **Landline / home telephone number** |
| **Child/young person mobile number** |  | | | | | **Parent’s/Carer’s mobile number** |  |
| **Is the Child / Young Person: (tick all that apply) –** | | | | | | | |
| □ Living with parents | □ Living with relatives | | | | | | □ Other (please state) |
| □ Looked After Child | □ Subject to a Child Protection Plan | | | | | | □ Adopted |
| First language: | | Interpreter required? □ Yes □ No  If yes, which language? | | | | | |
| Does the child/young person consider themselves to be transgender?  □ Yes □ No | | Sexual orientation:  □ Heterosexual □ Gay  □ Lesbian □ Bisexual □ Prefer not to say | | | | | |
| Does the child / young person have a disability?  □ Yes □ No  If Yes, Please specify: | Does the child / young person have a  Visual impairment □ Yes □ No  Hearing impairment □ Yes □ No | | | | | | Is the child / young person a Young Carer?  □ Yes □ No |
| **Name of GP** |  | | | | | **GP surgery name** |  |
| GP surgery telephone number and email address |  | | | | | GP surgery address: |  |
| **Ethnicity** | □ White British | | □ Irish | | | | □ Gypsy or Irish Traveller |
| □ White and Black Caribbean | | □ White and Black African | | | | □ White and Asian |
| □ Indian | □ Pakistani | | □ Chinese | | | | □ Bangladeshi |
| □ Any other Asian background | □ African | | □ Caribbean | | | | □ Other Black/Caribbean/African Background |
| □ Arab | □ Any other ethnic group – please state | | | | | |  |
|  | □ Any other mixed / multiple ethnic background – please state | | | | | |  |
| **Religion** | □ Agnostic □ Atheist □ Baha’I □ Buddhist □ Chinese (Taoist / Confucian)  □ Christian □ Hindu □ Humanist □ Japanese (Shinto) □ Jewish □ Jainism  □ Muslim □ Pagan □ Rastafarian □ Sikh □ Spiritualist  □ Do not wish to disclose □ Other | | | | | | |
| **SECTION TWO – PARENT/CARER DETAILS** | | | | | | | |
| **Who holds parental responsibility for the child /young person?** | | | | | | | |
| Forename |  | | Surname | | | |  |
| Relationship |  | | Telephone number: | | | |  |
| Address |  | | | | | | |
| **Is there any history of parental mental health difficulties and/or history of substance misuse?** □ Yes □ No | | | | | | | |
| If yes, please provide details: | | | | | | | |
| Are there any adult services currently involved? □ Yes □ No | | | | | | | |
| If yes, please provide details: | | | | | | | |
| **SECTION THREE – CHILDREN’S SERVICES** | | | | | | | |
| Name of Allocated Social Worker or Family Support Worker |  | | | | | | |
| Children’s Services Team |  | | | | | | |
| Address |  | | | | | | |
| Telephone |  | | | | | | |
| **SECTION FOUR - EDUCATION / NOT IN EDUCATION (NEET)** | | | | | | | |
| Name of School/College: | | | | | School/College address and telephone number: | | |
| Home school / Tutor | | | | | Please give details: | | |
| **SECTION FIVE – MENTAL HEALTH NEEDS AND CONCERNS** | | | | | | | |
| **Reasons for Referral –**  Please state nature of mental health difficulties, onset, frequency and duration, current presenting risk, interventions tried, impact on child and family, impact on education, and any relevant medical history: | | | | | | | |
| **What services have been accessed already?** | | | | | | | |
| **Is the young person on any current medication?** □ Yes □ No If Yes, please provide details: | | | | | | | |
| **Are there any concerns relating to substance misuse?** □ Yes □ No If Yes, please provide details: | | | | | | | |
| **Are there any concerns relating to food/weight/suspected eating disorder?** □ Yes □ No If Yes, please provide details: | | | | | | | |
| **SECTION SIX – REFERRER DETAILS** | | | | | | | |
| Name |  | | | Job Title/Profession: | | |  |
| Address | | | | | | | |
| Post Code: | | | | Telephone: | | |  |
| Date of Referral |  | | | Email address | | |  |
| **SECTION SEVEN - REFERRAL CONSENT** | | | | | | | **If no, please give reason** |
| Does the Parent/Carer know about the referral? | | | Yes | | | No |  |
| Does the Parent/Carer consent to the referral? | | | Yes | | | No |  |
| Does the Child/Young Person know about the referral? | | | Yes | | | No |  |
| Does the Child/Young Person consent to the referral? | | | Yes | | | No |  |
| **FORWARDING CONSENT** | | | | | | | **If no, please give reason** |
| Does the Child/Young Person/Carer give consent to forward the referral to the appropriate external agency e.g. Children’s Services, Education, Voluntary sector? | | | Yes | | | No |  |
| **For referral criteria, please see overleaf:** | | | | | | | |
| **SECTION EIGHT - REFERRAL CRITERIA** | | | | | | | |
| Psychosis (NB Consider referral to EIP team in presence of positive symptoms for 14 plus )   * Positive symptoms – Paranoia, delusional beliefs, abnormal perceptions (hallucinations on all sensory modalities) * Negative symptoms – deterioration in self-care and daily personal, social and family functioning * Disinhibited behaviour, over activity, risk taking, with pressure of speech and agitation * Severe depression with psychomotor retardation, social withdrawal, suicidal ideation | | | | | | | |
| Mood Disorders   * We provide a service to young people whose primary presenting problem is a mood disorder. This includes those presenting with moderate to severe depression as well as those young people who present with complex diagnostic issues involving mood and bipolar disorders | | | | | | | |
| Eating Disorders   * An early discussion around any possible eating disorder difficulties is strongly encouraged , we have a member of our ED team available on a daily basis for a consultation . * Anorexia Nervosa – an eating disorder characterised by excessive food restriction and an irrational fear of weight gain and distorted body image. It typically involves excessive weight loss * Bulimia – engaging in binge and purge behaviour * Eating Disorders – Other difficulties around food and eating. | | | | | | | |
| Significantly impairing Anxiety Disorders of a diagnosable level (e.g. OCD, PTSD)   * Severe or debilitating Anxiety panic attacks * Separation anxiety which severely impacts on the child’s functioning * Phobias including phobic anxiety | | | | | | | |
| **Depression**   * Physical symptoms – poor sleep / appetite / libido * Cognitive symptoms – negative thoughts about self / others / world * Social Symptoms , significant withdrawal from social activities, school, activities previously enjoyed.   These symptoms should have been present for a period of 2 weeks.   * Suicidal ideation – level on intent, current thought etc. * Co-morbidity – depression often occurs concurrently with other presenting mental health problems | | | | | | | |
| **Post Traumatic Stress Disorder**   * Symptoms occurring more than 3 months after a recognised traumatic event * Intrusion and avoidance of thoughts and memories about the trauma. * Revisiting site of trauma. * Hyper-vigilance, hyper-around and emotional numbing | | | | | | | |
| **Obsessive Compulsive Disorder**   * Obsessions and / or compulsions with functional impairment | | | | | | | |
| **Attention Deficit Hyperactivity Disorder (ADHD)**   * Significant difficulties in concentration and attention occurring in more than one environment e.g. home and school. Overactive, poorly modulated behaviour. | | | | | | | |
| **Deliberate Self Harm**   * Most commonly skin-cutting but might include burning, scratching, banging or hitting body parts, interfering with wound healing, hair-pulling (trichotillomania) and the ingestion of toxic substances or objects * May be associated with suicidal ideation and intent and/or a pattern of emotional dysregulation, interpersonal difficulty and maladaptive coping strategies | | | | | | | |
| **Complex Trauma**  Complex trauma occurs when an individual is exposed to multiple traumatic events with an impact on immediate and long-term outcomes.   * Symptoms are chronic and prolonged and may present as any from the list above, likely to occur within the context of sexual or physical abuse. * It impacts on development | | | | | | | |
| **ASC Assessment Only**   * Ongoing support provided by voluntary agencies | | | | | | | |