

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

Email completed referrals to **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 □ NoIf 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
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| 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
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| 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.
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| 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
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| **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
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| **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
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| **Obsessive Compulsive Disorder*** Obsessions and / or compulsions with functional impairment
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| **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.
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| **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
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| **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
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| **ASC Assessment Only*** Ongoing support provided by voluntary agencies
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