**SPECIALIST CHILDREN’S HEALTH SERVICE REFERRAL FORM**

**(Including CAMHS)**

**This referral may be returned if all sections of all 3 pages are not fully completed.**

**If referring to CAMHS Please also complete additional Appendices A and B.**

**Please write clearly in black ink.**

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| **Section 1** | | | | **Person Making Referral:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | | | Address: | | | |  | | | | | | | | | | | |
| Job Title: | | |  | | | | | | | | | | |  | | | |  | | | | | | | | | | | |
| Telephone: | | |  | | | | | | | | | | |  | | | |  | | | | | | | | | | | |
| Fax: | | |  | | | | | | | | | | | Email: | | | |  | | | | | | | | | | | |
| **Section 2** | | | | **Child / Young Person’s Details** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child’s Name:  (Surname) (First Name) | | | | | | | | | | | | | | | | M  F | | | | | | | Date of Birth | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | School / Nursery / College: | | | | | | |
| Postcode: | | | | | | | | Parents Mobile: | | | | | | | | | | | | | | | Language: | | | | | | |
| Home Telephone: | | | | | | | | Child’s Mobile: | | | | | | | | | | | | | | | Interpreter required:  Yes  No | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | | | Religion: | | | | | | |
| NHS Number: | | | | | | | | | Social Services ISIS No: | | | | | | | | | | | | | | Ethnicity: | | | | | | |
| GP Name: | | | | | | | | | | | | | | | | | | | | | | | Nationality: | | | | | | |
| GP Address / Surgery: | | | | | | | | | | | | | | | | | Subject to Child Protection Plan / Child In Need: Y  N | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | LAC Status: | | | | | | | | | | | | |
| **Section 3** | | | | **Parent or Carer’s Details** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Who has parental responsibility? | | | | | | | | | | | | | | | | | | | | Interpreter required:  Yes  No | | | | | | | | | |
| Parent / Carer’s Name: | | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | | |
| Address:  Postcode: | | | | | | | | | | | | | | | | | | | | Telephone: | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | Mobile: | | | | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 4** | | | | **Name of other Professionals / Agencies involved, if known:** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Social Worker | | | | | | | | | |  | | Nursery | | | | | | | | | | |  | Educational Psychologist | | | | |
|  | Court | | | | | | | | | |  | | Police | | | | | | | | | | |  | Educational Welfare Officer | | | | |
|  | Health Visitor | | | | | | | | | |  | | SENCo | | | | | | | | | | |  | Hospital/Community Doctor | | | | |
|  | CAMHS | | | | | | | | | |  | | Youth Offending Service | | | | | | | | | | |  | Children With Disabilities Team | | | | |
|  | Early Intervention | | | | | | | | | |  | | Child Development Team | | | | | | | | | | |  | Other (specify) | | | | |
|  | Other (specify): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 5** | | | | **Reason for referral and explanation of concerns including specific functional, sensory, motor difficulties, health, mental health or social needs or any identified risks (Please attach relevant reports e.g. school), if known and any other interventions already tried:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 6** | | | | **Please tick the boxes below to indicate the services you would like this referral to be passed:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Children’s Community Nursing Team | | | | | | | | | | Occupational Therapy | | | | | | | | | | | | 722 Drug & Alcohol Misuse Service | | | | | | | |
| Child Development Team | | | | | | | | | | Physiotherapy | | | | | | | | | | | | Primary Mental Health Team | | | | | | | |
| Community Paediatrician | | | | | | | | | | Social & Communication Clinic | | | | | | | | | | | | CAMHS Triage Team | | | | | | | |
| Speech & Language Therapy | | | | | | | | | | SEN Early Years | | | | | | | | | | | |  | | | | | | | |
| CAMHS ASD/ADHD Assessment (**please follow instructions in Appendix B**)  Previous CAMHS ASD/ADHD Assessment completed?  Yes  No (if ‘Yes’, attach report)  If ‘Yes’, was a diagnosis given?  Yes  No  If ‘Yes’, state diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 7** | | | | **Medical Information (i.e. birth history, current health issues, medication, admission/discharge details, allergies, feeding related coughing, choking, vomiting, chest infection), if known. Attach relevant medical / other reports:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Complete where relevant (e.g. eating disorders or food refusal/aversion):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height: | |  | | | | Weight: | | | | | |  | | | | | BP: | |  | | | | | | | Pulse: | | |  |
| **Section 8** | | | | **Developmental History and Milestones:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Age of smiling: | | | | |  | | Age of sitting: | | | | | | | |  | | | | | | Date of Hearing Test: | | | | | | |  | |
| Age of walking: | | | | |  | | Age of first words: | | | | | | | |  | | | | | | Date of Eye Test: | | | | | | |  | |
| Comments (including other milestones): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 9** | | | | **Parent’s/Carer’s concerns and expectations / History of difficulties (date of onset, are the symptoms stable or worsening, what was tried/what has worked so far) / Impact of the difficulties on the young person and family:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 10** | | | | **Family History (including family composition, support network, others with illness or disability in the family, family history of mental health / substance misuse) and if other siblings are known to child health services:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 11** | | | | **Social History (including any child protection concerns) / Background Information (family difficulties, bereavement, parental illness or separation, change of home or school):** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 12** | | | | **Other relevant information (including mental health concerns):** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 13** | | | | **Information Sharing And Consent:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Information about your child may be shared with other teams and agencies (eg Education services, Children’s Centres and social care) in order to identify the most appropriate support for your child.  Has the referral been discussed with the parent or carer?  **Yes  No**  Has the referral been discussed with the child or young person?  **Yes  No**  Is there parental consent for enquiry/onward referral to other agencies?  **Yes  No**  Is there parental consent to contact school?  **Yes  No**  Is there child consent to be contacted whilst at school?  **Yes  No**    **Comments (if any):**  **Signed (Parent/Carer)       Name:       (if applicable for Community Health – see guide)**  **Signed (referrer):** **Name:**    **Relationship:** **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Office Use Only** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name and designation of receiver: | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | SCS ID: | | | |
| Passed to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **APPENDIX A**  To be completed for all CAMHS referrals only | |
| **Question 1** | **What are the young person’s current difficulties at this time (for example current behaviours, school impacts or social impacts)?** |
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| **Question 2** | **What is the history of the difficulties (When did they start? Have they worsened?)** |
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| **Question 3** | **What has been already tried to help the Young Person?** |
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| **Question 4** | **Are there any social or parental difficulties to make us aware of?** |
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| **Question 5** | **What does the Young Person hope to achieve by coming to CAMHS? / What are their goals?** |
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| **Consent** | **Please be aware that the referral will not be accepted unless this consent section is completed** |
|  | **Do the parents consent to CAMHS contacting the school?  Yes  No**  **Does the Young Person consent to being contacted at school?  Yes  No** |

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| **APPENDIX B**  For referrals to CAMHS for ASD and/or ADHD |
| From 5th July 2018 Waltham Forest CAMHS will be open to accepting routine referrals for ASD or ADHD. We have made changes to the procedure for these referrals in order to allow us to process these more efficiently and to accept young people who require an assessment more quickly onto our pathway. Please note:   * **A diagnosis of ASD or ADHD is not required for an Education, Health and Care needs assessment to be requested from the Local Authority (as this application is based on a child’s needs or functioning rather than on a diagnosis)** * **We request that our General Practitioner colleagues do not make routine referrals to CAMHS for ASD or ADHD assessments and instead redirect parents of school age children to approach the young person’s school. Schools generally know the young person best and should compile all the required information and send it in with their referral** * **We will require the screening information detailed below to be fully completed as part of the referral and should be enclosed with any referral for possible ASD or ADHD** * **Any referral without complete paperwork will be returned to the referrer.**   **To be completed by school:**  Please open and complete the documents below, then send them back with this referral form.   |  |  | | --- | --- | | School Report (for ASD or ADHD) |  | | CAST (For ASD) |  | | SNAP 26 (for ADHD) |  |   Note: In cases where there is suspected significant learning delay, inclusion of a recent Educational Psychology Report and/or Speech and Language Report will be beneficial to expedite processing of the referral and decisions about diagnosis.  **To be completed by parents:**  Please open and ensure parents complete the documents below, then send them back with this referral form.   |  |  | | --- | --- | | CAST (for ASD) |  | | SNAP 26 (for ADHD) |  |   An email confirming receipt of a complete referral will be sent to the referrer. If this referral is not accompanied by the completed forms mentioned above, this form will be returned to the referrer, and the referral will not be opened.  Once the referral has been clinically screened, the outcome will be communicated in writing to the referrer and GP.  Referrals for tics or Tourettes will not require the above forms to be completed. |