|  |  |
| --- | --- |
| Return completed form to:  [oxfordhealth.fcamhssouthwestnorth@nhs.net](mailto:oxfordhealth.fcamhssouthwestnorth@nhs.net)  Community FCAMHS South West (North)  Temple House, Temple Court, Keynsham, Bristol, BS31 1HA  Tel: 01865 903038 |  |
| **South West (North) Community FCAMHS Referral Form** | |

Please complete as fully as possible by typing into the white spaces

|  |  |
| --- | --- |
| **Office use only** | |
| Referral received |  |
| Consultation date |  |

|  |  |
| --- | --- |
| **Date of Referral** |  |

|  |  |
| --- | --- |
| **Young Person information** | |
| Name |  |
| Date of Birth |  |
| NHS Number |  |
| Age at referral |  |
| Gender |  |
| Ethnicity |  |
| Religion |  |
| Home address |  |
| Telephone |  |
| Address at time of referral  (if different) |  |
| Telephone |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Consent** | | | | |
| Consent obtained for referral? | Yes |  | No |  |
| If no, is there a good reason why the referral should be accepted without consent (e.g. particular safeguarding/imminent risk concerns)? | Yes |  | No |  |
| If no, please state reason:  **Please note, by submitting this referral, you are also confirming that you have followed your local consent policies. This includes gaining the relevant consent for referring to our service, and the sharing of appropriate information across agencies involved.** |  | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Next of kin/carer information** | | | | | |
| Name |  | | | | |
| Address |  | | | | |
| Telephone |  | | | | |
| Aware of the referral? | | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GP** | | | | | |
| Name |  | | | | |
| Address |  | | | | |
| Telephone |  | | | | |
| Aware of the referral? | | Yes |  | No |  |

|  |  |
| --- | --- |
| **Referrer’s information** | |
| Name |  |
| Job title |  |
| Address |  |
| Telephone |  |
| Email |  |
| Please state availability for contact |  |

|  |  |
| --- | --- |
| **Other professionals involved** | |
| Please give names, roles, telephone and email |  |

|  |  |
| --- | --- |
| **Who is the lead / co-ordinating professional?** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Previous CAMHS (not FCAMHS) contact?** | Yes |  | No |  | Unknown |  |
| **Has the young person been previously known to this service?** | Yes |  | No |  | Unknown |  |

|  |  |
| --- | --- |
| **Other agencies involved at time of referral** | |
| CAMHS |  |
| Education |  |
| Social Care |  |
| Police |  |
| YOS |  |
| Other |  |
| None |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Living arrangements at time of referral** | | | | | | |
| Birth family |  | Criminal justice setting: | | | Mental health setting: | |
| Adoptive family |  | YOI | |  | Open unit |  |
| Other family |  | STC | |  | PICU |  |
| Foster care |  | SCH | |  | Low secure |  |
| Residential care |  |  | | | Medium secure |  |
| Secure care (welfare) |  |  | |
| Residential school |  | Other (please state) |  | | | |
| Semi-Independent living |  |  | | | | |
| Independent living |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Social Care status** | | | **Education status** | | |
| LAC – s.20 | |  | Mainstream | |  |
| LAC – s.31 | |  | Mainstream with SEN | |  |
| Leaving care | |  | Special schooling | |  |
| Child in Need | |  | PRU | |  |
| Team Around the Child | |  | Home tuition | |  |
| Subject to CP plan | |  | Hospital school | |  |
| Secure Accommodation Order - s.25 | |  | Further education | |  |
| None | |  | Vocational training | |  |
| Other (please state) |  | | NEET | |  |
|  | | | EHC Plan | |  |
| Left School | |  |
| Other (please state) |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criminal Justice status** | | | | |
| Not applicable | |  | On bail |  |
| On remand | |  | Pre Court order |  |
| Community sentence | |  | Custodial sentence |  |
| Other (please state) |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Has a Common Assessment Framework (CAF) been completed?** | **Yes** |  | **No** |  | **Unknown** |  |
| **If yes, please attach a copy to this referral** | | | | | | |

|  |
| --- |
| **Reason for Referral**  **Please identify any specific events or incidents of concern (including dates)** |
| **Please identify risk of harm to others:**  **Please identify mental health concerns or diagnoses:** |
| **Significant life events or changes. E.G. Trauma, bereavement.** |
|  |
| **Disabilities including physical health difficulties and learning difficulties. Please identify any previous diagnoses.** |
|  |

|  |
| --- |
| **Referrer’s anticipated outcome**  **Please include the young person’s view if possible** |
|  |

|  |
| --- |
| OFFICE ONLY: Info checked at consultation 🞎 |