NHS North West Boroughs Healthcare NHS Foundation Trust

CONFIDENTIAL

Affix ID label here or complete the following information	
Patient ID number	
Service user name: **Mandatory**	
NHS Number: **Mandatory**	
Date of birth	
Team	

CYPMHS St Helens: Children and Young Peoples Mental Health Services

Believe in children Barnardo's

This referral form is for access to CYPMH Services incorporating North West Boroughs Healthcare NHS Foundation Trust and Barnardo's across the Borough of St Helens. Your referral will be reviewed by representatives from both organisations. Onward referral to other agencies will be completed on your behalf where clear consent is included on this form.

Name: Gender: M/F/Other DOB: / / Address: Postcode: Ethnicity: First language: Special consideration for communication:	NHS number: Previous surnames: Main telephone number: Other telephone number: Consent to leave voicemail message? Yes/No Preferred method of contact: Who holds parental responsibility?
Parent(s)/ Carer(s) Name: Address (*if different from child)*: Post code:	Parent(s)/ Carer(s) main contact number: Parent(s)/ Carer(s) alternative number: Email address:
School/College: Year/Group: Key contact: Is there a statement of educational need? **Yes** □ **No** □ Is there a EHCP ? **Yes** □ **No** □ **(If yes please enclose)** Learning disabilities? **Yes** □ **No** □ Autistic Spectrum Disorder (ASD)? **Yes** □ **No** □ Is there a CAF/TAF currently in place? **Yes** □ **No** □ **(if Yes please enclose)**	**Legal status:** Is the child: Living with parent/carer with parental responsibility ☐ Voluntarily Accommodated by the Local Authority (s 20) ☐ Subject to Care Order (s 31) ☐ **If s20 or s31 are they placed in:** Foster care ☐ Residential care ☐ With parents ☐ **Is the child subject of:** Child in Need Plan ☐ Child Protection Plan ☐ Child in Care (LAC) Plan ☐ **SDQ Score:** **Parent/Carer:** **Young Person:** **Professional:**

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School Attendance:

No concerns ☐ Some concerns ☐ Strong concerns ☐ Referral to EWO ☐

Comments:

General Practitioner details:

Doctor:

Surgery address:

Postcode: Telephone number:

Who Initiated this Referral?

Please tell us who is asking for help by circling the appropriate answer:

Young Person **Parent/Carer** **Professional** **Other**

Description of presenting issue:

Please include any possible triggers, duration and severity of issues, method and frequency of any self-harm:

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Name: **NHS number:**

Reason for referral:

Deliberate self-harm	**Yes** □ **No** □
Suicidal ideation	**Yes** □ **No** □
Depression	**Yes** □ **No** □
Anxiety disorder	**Yes** □ **No** □
Psychosis	**Yes** □ **No** □
Eating disorders	**Yes** □ **No** □
Mood disorders	**Yes** □ **No** □
Behaviour	**Yes** □ **No** □
Bereavement	**Yes** □ **No** □
Trauma	**Yes** □ **No** □
Other (Please state)	

Risk/Vulnerability Factors:

Alcohol Misuse	**Yes** □ **No** □
Drug Misuse	**Yes** □ **No** □
Criminal Behaviour	**Yes** □ **No** □
Domestic Abuse	**Yes** □ **No** □
Child Sexual Exploitation (CSE)	**Yes** □ **No** □
Autistic Spectrum Disorder (ASD)	**Yes** □ **No** □
Attention Deficit Hyperactivity Disorder (ADHD)	**Yes** □ **No** □
Home visit safety issues (e.g dogs, needles, family members) Please state risk:	**Yes** □ **No** □
Is young person pregnant? If yes please state due date: Name of midwife:	**Yes** □ **No** □
Is young person a parent? If yes please give Health Visitor/Midwife details:	**Yes** □ **No** □
Is young person a young carer?	**Yes** □ **No** □
Is young person a Dependant of an ex-services member or an ex service member	**Yes** □ **No** □

Other service/professional involvement:

Service	Name and contact details	Date(s) of involvement	Reason for involvement

Consent: **Mandatory Field**

Has the referrer met with child or young person? **Yes** □ **No** □
Has the child/young person given consent to referral? **Yes** □ **No** □
Has the parent/guardian given consent to referral? **Yes** □ **No** □

If the child is under 16 years of age has the parent / carer consented to transfer of referral information to CAMHS or other partnership agency if assessed as more appropriate for their needs **Yes** □ **No** □

If the young person is over 16 years of age have they consented to transfer of referral information to CAMHS or other partnership agency if assessed as more appropriate for their needs **Yes** □ **No** □

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Name: **NHS number:**

Details of any previous advice, treatment or interventions:
Please include medications, allergies and recent physical assessments/investigations

Details of any current treatment:

Are there any Safeguarding concerns?
If so please specify
Expand on any risk/vulnerability factors in respect of Safeguarding

Please highlight requested response *(please call Duty to discuss if unsure and always call to discuss Emergency referrals BEFORE sending)*

Emergency (24 hours)	Routine
i.e High risk to self/others and/or acute psychiatric concern	*i.e concerns regarding emotional health/mental state/risk/behaviour that can be managed safely by family and other agencies until assessment*
EMERGENCY referrals send to 5bp-tr.CAMHS-referrals@nhs.net Or Fax 01925 664191 Or contact the Response Team on 01744 627618	ROUTINE referrals send to nwbh.camhssthelensreferrals@nhs.net Or contact St Helens CAMHS team on 01925 579405

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Referrer details:

Referrer name: Contact number:

Job title/Profession: Date of request:

Address: Email address:

Thank You