Mental Health Support Team Referral Form

When making a referral about a child or young person we ask that all young people aged 12 years or above provide their consent to any referral for themselves unless they are not capable of understanding this request or the content of this form.

If the child or young person is under 16 years old, the referrer will need to assess the young person's Gillick competence in relation to them providing consent. If the young person is competent then we respect their wishes to consent or not to this referral unless there is a level risk of relative harm to the child/young person or someone else.

If the child or young person cannot consent, then consent must be obtained from an authorised individual with parental responsibility for the child/young person.

PLEASE NOTE:
IF THIS FORM IS INCOMPLETE WE WILL BE UNABLE TO PROCESS THE REFERRAL

Consent

Consent (please tick the box to confirm this)

- ☐ I agree that I have gained consent from the young person or an authorised individual with parental responsibility for the child before submitting this referral form. I have informed them that their information will be shared with St Helens MHST (part of North West Boroughs Healthcare NHS Foundation Trust) and that this information will be recorded on the electronic patient record system (RiO)

- ☐ If the child is under 16 years - has the parent / carer consented to transfer of referral information to CAMHS or other partner agency if assessed as more appropriate for their needs

- ☐ If the young person is over 16 years - have they consented to transfer of referral information to CAMHS or other partnership agency if assessed as more appropriate for their needs

Date of referral	
Referrer name	
Referrer job role	
School name	
Telephone number	

Personal details (child / young person)	
Name: Gender (m/f): Date of birth (dd/mm/yy): Address: Postcode: First language: Special consideration for communication:	NHS number: Previous surnames: Main telephone number: Other telephone number: Consent to leave voicemail message (y/n): Preferred method of contact: Ethnicity:

Personal details (parent / carer)	
Both Parent(s) / carer(s) name: Addresses (if different from child): Postcode: Who holds Parental Responsibility? Next of kin?	Parent(s) / carer(s) main contact number: Email address: Consent to leave voicemail message (y/n)? Preferred method of contact:

Young person's GP details:	
General Practitioner details: GP name: GP surgery address: Postcode:	Telephone number:

School information		
Child/Young Person's School Year: Name of key contact (mental health lead/coordinator):		
	Yes	**No**
Is there a statement of educational need?	☐	☐
Is there an Education, Health and Care Plan (EHCP) in place? (If yes, please forward a copy of the plan with this form)	☐	☐
Does the pupil have any neurodevelopmental needs e.g. learning disability, ASD, ADHD? If "yes" please provide further details; …… ……	☐	☐

Safeguarding

Is the child subject to:	Yes	No
Child in Need Plan (CIN):	☐	☐
Child Protection Plan:	☐	☐
Child in Care (CIC) Plan:	☐	☐
Is there a CAF/TAF currently in place?	☐	☐

If yes, please forward a copy of any plans, including Social Worker, Early Help or CAF/TAF Lead contact details, with this form.

Presenting emotional health and wellbeing issues

Does the pupil have any on-going referrals to the following services?	Yes	No
CAMHS	☐	☐
St Joseph's/Barnardo's	☐	☐
Child Development Centre/ ASD Service	☐	☐
Bereavement Services	☐	☐
RASAC	☐	☐
Other please state	☐	☐

Primary intervention need	Yes	No
Low mood / depression – possible intervention would involve; Aged 10-18 years - Behavioural Activation	☐	☐
Anxiety (e.g. separation anxiety, worry management) – possible intervention would involve; Aged 8 years plus - Worry Management Aged 5-12 years - Parenting for worry management (Cathy Creswell model)	☐	☐
Behavioural / conduct difficulties– possible intervention would involve; Aged 5-12 years - Parenting Intervention for Behaviour	☐	☐
Specific Phobias (e.g. mild social phobia) – possible intervention would involve; Aged 8 years plus - Exposure Therapy for mild phobias	☐	☐

Preferred intervention type:

Individual face-to-face ☐ Group work (child / young person) ☐

Brief description of presenting issue(s):

Onset of issues (when did issues commence, are they long-standing, etc.)

Possible triggers (what seems to cause or make the issues occur?)

Symptoms (e.g. anxiety, low mood or behaviour symptoms)

Duration (e.g. how long do the issues or symptoms last for generally? Is this increasing?)

Severity of issues (how do issues impact on the young person's functioning across settings – use 0 to 10 scale of 0=not at all and 10=very much, and, identify relevant score)

	1	2	3	4	5	6	7	8	9	10
School	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Home	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Socially	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Risk / vulnerability factors:

Risk/vulnerability factors – please tick and specify current issues in "presenting issues" section above	Current	Historical	None
Self-harm	☐	☐	☐
Substance use (drugs, alcohol)	☐	☐	☐
Antisocial behaviour	☐	☐	☐
Friendship difficulties (inc. Bullying)	☐	☐	☐
Domestic Abuse	☐	☐	☐
Child Sexual Exploitation	☐	☐	☐
Is young person a young carer?	☐	☐	☐
Is young Person pregnant? If yes, please state due date: Name of Midwife:	☐	☐	☐
Is young person a parent? If yes, please confirm name of midwife and/or health visitor:	☐	☐	☐

Declaration

Declaration

As part of providing you with direct care, the Trust may have to share your information with other partner organisations. To find out more information about this, please refer to our Privacy Policy.

By emailing this form to the Mental Health Support Team, I agree to the Trust contacting me using the details given above. I understand that the Trust will:

- Securely store the information relating to my referral (and subsequent care, where applicable) in paper and/or electronic format
- Keep the records for as long as required in the Records Management Code of Practice for Health and Social Care 2016 (or for longer if it is appropriate)
- Confidentially destroy records when necessary

Please email your completed form to
nwbh.mhst-sthelens@nhs.net

The service will aim to respond to your referral within 2 working days