**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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name and designation of receiver: | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | SCS ID: | | | |
| Passed to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |