# SOLIHULL CHILD AND ADOLESCENT MENTAL HEALTH SERVICE
# REFERRAL FORM

Please note that the referral forms are generic, and are designed to be filled in by a range of professionals –
**The most important parts to be filled in are the mandatory sections 1 2, 3 and 4, although the description of the problems may be provided in the form of a typed letter attached to the referral form. Sections 7 & 8 can be used by you or your staff to provide any other additional information. This may be helpful and speed up the process.**

**Please ensure that you include or attach the most recent CAF should one have been completed.**

**Please ensure that the form is completed as fully as possible as omissions may delay the referral.**

| **1. Details of baby, child or young person** | | | | | |
|---|---|---|---|---|---|
| First Name: | | | | | |
| Family Name: | | | NHS Number: | | |
| Alternative Name: | | | | | |
| Date of Birth: | | Age | | | |
| Current Address : | | | | | |
| Post Code: | | | Tel No: | | |
| Ethnicity: | | | Religion: [if known) | | |
| Gender: | Female : ☐ Male: ☐ | First Language: | | Interpreter Needed: Yes ☐ No ☐ | |
| Current School: | | | | | |
| Disability: [*please describe the nature of disability]* | | | | | |

| **2. Details of all persons with parental responsibility** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Parent / Carer Name: | | | | Parent / Carer Name: | | | |
| Date of Birth: | | | | Date of Birth: | | | |
| Address: | | | | Address: | | | |
| Post code: | | Tel No: | | Post Code: | | Tel No: | |
| Relationship: | | | | Relationship: | | | |

| **3. Care status**: Current legal status, Orders & dates | |
|---|---|
| Looked After?(i.e. under care of Local Authority) | Children Act Section: |

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| | |
|---|---|
| Yes ☐ No ☐(e.g. foster /residential care or adoption] | Name of Social Worker: |

**4. Description of concerns**

The description of the difficulties may be provided in the form of a typed letter attached to the referral form if necessary

**A. Current Situation (Please describe below what is happening, where and when, frequency, duration, giving examples of specific incidents or events where possible. and impact bearing**

such as the impact on Physical Health, Education, Self Esteem, Emotional Well being, Relationships,

**B. History (Please explain below background to problems, is it worsening or stable. what has been tried, what has worked so far?)**

**Other** – are there any other influences that may impact on the current difficulties?
e.g. parental separation, family health, poor housing etctc. Please describe below.

**C. What service(s) are you requesting from CAMHS and what outcome do you expect?**

**5. Other Agency involvement Past or Present**

(Please circle and complete details below and specify whether involvement is Past or Present)

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**Health -** GP, Paediatrician, Health visitor, School Nurse, CPN, Psychologists. **Education -** SENCo, Ed Psych Behaviour Support Services [Is Child on the code of practice] Yes ☐ No ☐ {If yes, what stage?} _____
**Families Directorate -** Social Worker**,** Respite
Private and Voluntary Organisations:

**Please provide details of agencies involved**

| **Name of Agency:** | **Contact Name:** | **Tel No:** |
|---|---|---|
| | | |
| | | |
| | | |

**6. Agreement to / Awareness of Referral**

Who is aware of this referral and are they in agreement with it, can we contact them?

**Child** Aware? Yes ☐ No ☐ In agreement? Yes ☐ No ☐
**Parent** Aware? Yes ☐ No ☐ In agreement? Yes ☐ No ☐
**G. P.** Aware? Yes ☐ No ☐ In agreement? Yes ☐ No ☐
**School** Aware? Yes ☐ No ☐

**7. GP's Details:**

| **Name of GP:** | **Name of Practice:** |
|---|---|
| **Address:** | |
| **Post code:** | **Tel No:** |

**8. Referrer's Details** [If GP is not referrer]

| **Name of referrer:** | **Job title / Role:** |
|---|---|
| **Address:** | |
| **Post code:** | **Tel No:** |
| **Signature of referrer;** | **Date;** |

**Data Protection/Confidentiality**

**The information on this form will be used to assess the need for a service to meet the emotional and mental health needs of the referred child/young person and will be shared with other agencies, where this is necessary, in order to provisionally assess the need to provide an appropriate service.**

| | | |
|---|---|---|
| ***** Young Person/Parent/Carer has given consent to allow the sharing of information multi-agency** *[*** please delete as appropriate]* | **Signed:** **Date:** | |

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**Please return to:**

Solihull CAMHS
Kingshurst Clinc
Marston Drive
Kingshurst
B37 6BD
Telephone: 0121 329 1900
Fax: 0121 329 1901