

Please ensure that the form is completed fully as omissions may delay the referral. For discussion on whether a referral is appropriate please contact the Single Point of Access at Ty Llewelyn on 01267 674450.

Please send completed referrals to : Access.S-CAMHS.HDD@wales.nhs.uk

REFERRER DETAILS

NAME OF REFERRER:

Date of referral:

Details of Referrer: (address, telephone, profession)

Signature of Referrer:

Have you seen the child prior to making this Referral? YES / NO

Has Client /Parent/Carer/Guardian provided consent for a Referral to Specialist CAMHS?

YES / NO (PLEASE CIRCLE)

1. Child's Details

Family Name:

Forenames:

Previous Surname:

Preferred Name:

Date of Birth:

Age:

Gender :

NHS Number:

Current Address & Post Code

Permanent Address & Post Code(if different):

Tel No:

GP Name:

Address:

Post Code:

Ethnicity:

Tel No:

Preferred language:

Parents Preferred Language:

Reading Language:

Interpreter required? Yes / No

Communication Issues? (Including sensory loss)

Religion:

Religious Support requested? Yes / No

Immigration Status:

Home Office Number:

Disability:

Current Medication:

Known Allergies:

1. Description of Present Concerns - (describe the problem- where, when, frequency and duration. Describe any relevant life events or recent changes. Give examples of specific risk concerns or events where possible)

2. WHAT IMPACT DOES IT HAVE ON THE FOLLOWING AREAS? Home, Family, Education, Health, Relationships etc. ...

3. HISTORY (Please explain background to problems, is it worsening or stable, what has been tried in the past, what has worked so far? Family history of Mental Health and previous risk problems)

4. WHAT ARE YOUR EXPECTATIONS FROM SPECIALIST CAMHS

5. FURTHER INFORMATION (please indicate any further relevant information attached with this referral)
 If additional information please tick box

6. HOUSEHOLD DETAILS: (continue on reverse if necessary)

a) PARENTS/CARERS AND OTHER ADULTS LIVING AT SAME ADDRESS AS CHILD

Name	Date of birth	Relationship to child	Parental responsibility
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b) CHILDREN & YOUNG PEOPLE LIVING WITH CHILD

Name	Date of birth	Relationship to child	Gender	Legal Status
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7. OTHER PROFESSIONALS INVOLVED

Name		Name	
Role		Role	
Organisation		Organisation	
Tel No		Tel No	
Fax No		Fax No	

Name		Name	
Role		Role	
Organisation		Organisation	
Tel No		Tel No	
Fax No		Fax No	

SOCIAL CARE REFERRALS ONLY

STATUS OF REFERRED CHILD:

Care Order	Yes/No	Care proceedings underway	Yes/No
Accommodated	Yes/No	Supervision Order	Yes/No
Child in need	Yes/No	Other (please specify)	

HAS THERE BEEN CONCERN ABOUT:

Physical Abuse	Evidence of Suspicion of <input type="checkbox"/>	Sexual Abuse	Evidence of Suspicion of <input type="checkbox"/>	Emotional Abuse	Evidence of Suspicion of <input type="checkbox"/>	Neglect	Evidence of Suspicion of <input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Has a Core Assessment been undertaken? **Yes/No**
IF YES PLEASE ATTACH A COPY

Has a C.P. Conference been held? **Yes/No**
IF YES PLEASE ATTACH A COPY OF RECENT MINUTES/CHILD PROTECTION PLAN

Has A Risk Assessment been undertaken? **Yes/No**
IF YES PLEASE ATTACH A COPY OF THE RISK ASSESSMENT REPORT

Is there a Care Plan? **Yes/No**
IF YES PLEASE ATTACH A COPY

Has there been a recent statutory review? **Yes/No**
IF YES PLEASE ATTACH A COPY OF COMPLETED L.A.C FORM

HAVE ANY OTHER SPECIALIST ASSESSMENTS BEEN CARRIED OUT RELEVANT TO THIS REFERRAL? YES/NO
IF YES PLEASE SEEK CONSENT TO FORWARD A COPY. PLEASE INDICATE IF CONSENT WAS WITHELD

MAIN PURPOSE OF SOCIAL CARE INVOLVEMENT:

ANY EVENT/DECISION GIVING RISE TO THE REFERRAL AT THIS PARTICULAR TIME

IS THE MAIN OBJECTIVE OF THE REFERRAL FOR:

Further Assessment? Yes/No; Consultation? Yes/No; Therapeutic Work? Yes/No

WHO DO YOU FEEL NEEDS TO ATTEND AN INITIAL APPOINTMENT (e.g. S.W, child, parents, carers, other professionals)

Signature of Referrer: **PRINT NAME:**

Signature of Team Manager: **PRINT NAME:**

Date of Referral: