Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (C.A.M.H.S.)

(Including Children's Learning Disability Services)

Referrals to be sent to: Mulberry Centre, Hollyhurst Road, Darlington, DL3 6HX / secure email address: TEWV.CAMHSCountyDurhamDarlington@nhs.net

CONSULTATION / REFERRAL FORM (*Please circle*)

PART ONE

CONSENT

Young person / Parent / Carer consent for consultation / referral? **Yes** **No**

Young person / Parent / Carer consent to leave telephone messages / text? **Yes** **No**

DATE FORM COMPLETED: **DATE RECEIVED:**

CHILD / YOUNG PERSON

Name ………………………………………………………………… NHS No. …………………………………………………

Address ………

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Postcode ………………………………………… Tel No ……………………………………………………………………

D.O.B. ………………………………………….. Gender: Male ☐ Female ☐

Ethnicity ……………………………… ………….. Previously known to services? CAMHS ☐ Children's LD ☐

PERSON WITH PARENTAL RESPONSIBILITY

Name …………………………………………………… Relationship ……………………………………………………

Address ………

Post Code …………………………………………….. Tel No (home) ……………………………………………

Tel No (work) ……………………………………………. Tel No (mobile)……………………………………………

GP NAME ……………………………………………

GP Practice ……………………………………………

Address ……………………………………………

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Tel No ……………………………………………

Is GP (if not referrer) aware of referral? YES / NO

SCHOOL / FURTHER EDUCATION / COLLEGE / EMPLOYMENT

……………………………………………………………

Key contact (if known) ……………………………………

Tel Number……………………………………………

Does the child / young person have a diagnosed learning disability? **Yes / No**

Wheelchair Access required?

Yes / No

Interpreter Required (if yes please specify language)?

Yes / No

CONSULTATION / REFERRER DETAILS

Name ……………………………………………………………Profession ……………………………………………………

Address ………

Postcode ………………………………………………… Tel No ……………………………………………………………

C.A.M.H.S. ONLY - ACTUAL OUTCOME OF CONSULTATION / REFERRAL

TIER 3 **TIER 2** **UNIVERSAL / OTHER SERVICES (Please state)**………………………………

PART TWO

FAMILY COMPOSITION / SITUATION …………………………………………………………………………………………....

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REASON FOR MENTAL HEALTH CONSULTATION / REFERRAL (Summary of emotional / mental health concerns, including context in which they occur, duration of problem/when the current problem arose)

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Please continue on a separate sheet if required

SUICIDAL IDEATION / EPISODE OF SELF HARM / RISK FACTORS (Description of event or summarise reasons for concern eg harm to others, school or placement breakdown, child protection, environmental risks to home visits)

IS THERE ANY IMMEDIATE AND SIGNIFICANT RISK TO SELF OR OTHERS? Yes / No

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Please continue on a separate sheet if required

RELEVANT HISTORY (Past CAMHS referral, learning difficulties/learning disability, IQ, development, key life events, previous illness and treatments, relevant inpatient, physical health problems, parental mental health issues, e.g. post natal depression)

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Other Agencies Involved (inc Health Visitor/School Nurse/Counsellor/Social Worker/S</EWO/Community Paeds/ One Point) & name of contact

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Please attach any available reports eg educational statement, school report, initial or core assessment, educational psychology report.

THERAPIES / TREATMENTS OFFERED PRIOR TO CONSULTATION / REFERRAL (*e.g. Counselling, Parenting Groups, Behaviour Management, Medication*)

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EXPECTED OUTCOMES FROM THIS CONSULTATION / REFERRAL?

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