Child & Adolescent Mental Health Service  
CAMHS SPOA - Referral Form

*Please use this form for all Barnet, Enfield and Haringey CAMHS Services.*

*Please complete and return to beh-tr.camhs-spoa@nhs.net*

*Phone: 0208 702 3111*

Please note:

* If you consider this referral to be an emergency, please call 999
* If you consider this referral to be urgent, please call the SPOA line to speak to a CAMHS SPA Clinician
* If this is a re-referral and the young person is deteriorating or there are new concerns following on from your referral, please send this updated information of the client’s presentation via our mailbox or alternatively contact us on 0208 702 3111 to speak to a CAMHS SPA clinician consultation.
* ALL FIELDS ARE MANDATORY unless otherwise specified. Incomplete referral forms cannot be processed until all required information has been obtained; please ensure you complete all fields to avoid delays.
* The quality of the information you provide will help us to process and prioritise this referral more effectively.
* **All referrals MUST be emailed to** [**beh-tr.camhs-spoa@nhs.net**](mailto:beh-tr.camhs-spoa@nhs.net) **as from 1st of April 2024**

Consent (We are unable to proceed with your referral without this information)

Is the child/young person aware of this CAMHS referral and is consent given?  Yes  No *If no, details:*

Is the parent/carer aware of this CAMHS referral and is consent given?  Yes  No *If no, details:*

If the young person is being referred without parental consent, please explain why and indicate how the young person should be contacted:

Referrer Information

|  |  |
| --- | --- |
| Name of Referrer:  Position:  Address:  Postcode | Tel No :  Fax No: |

Client Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name Of Referred Child/Young Person | | Date Of Birth | | Male  / Female |
| Current Address  Postcode | | Home Telephone | | Client’s Mobile No |
| Ethnicity | | Main Language Spoken |
| NHS Number | | Interpreter Needed  YES  / NO |
| Has the child/young person agreed to this referral (if appropriate)?  YES  / NO | Is he/she able to travel to appointments?    YES  / NO | | Is s/he on a Child Protection or Child in Need Plan?    YES  / NO | |
| Name and address of GP | | Name and address of school/college | | |

Parent /Guardian/Carer Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Who does the young person live with?  NAME RELATIONSHIP | | | Did they agree to this referral?  YES  / NO | Accommodated by the local authority  YES  / NO |
| Mobile number | Ethnicity | | Main language spoken? | Interpreter required?  YES / NO |
| Who should correspondence be address to? ( i.e. carer and child, mother and child, father and child, parents and child, other): | | | | |
| Name of person(s) with parental responsibility (if different from above)  NAME RELATIONSHIP | | | | Are they aware of the referral?  YES  / NO |
| Address (if different to above) | | | | |
| Other members of the household (please list)  NAME RELATIONSHIP | | Significant others if not in household (please list)  NAME RELATIONSHIP | | |

Parental Permission

|  |  |
| --- | --- |
| I/We are in agreement with this referral to CAMHS; and  I/We give consent for my/our child to be seen individually  if considered necessary.    CONSENT TO CONTACT  As part of our work with a child or young person and their family, it is often helpful to contact other professionals/organisations involved in order for us to have as full a picture of the situation as possible. We are asking for your consent below to allow us to request and share information on you (the young person)/your child with these services. We are required to keep your GP informed about your contact with this service.  I consent ☐ for the Child and Adolescent Mental Health Service to contact the following:  Educational Psychologists ☐ School/Nursery ☐  Other ☐ | Signed |
| Print Name(s) |

Referral information

|  |
| --- |
| Reason for referral *(presenting problem, duration, severity including the nature of mental health concern)* |
| Background information *(e.g. significant family difficulties, bereavement, illness parental separation, change and home or school):* |
| What is the referrer hoping to achieve by making this referral? |
| Please give relevant medical history/current medication. |

Legal Status of Young Person *(please complete / tick as appropriate)*

|  |  |
| --- | --- |
| Name of Social Worker  Address | Telephone number  Fax number |
| Are there any pending Court Proceedings?   * If YES please give details (e.g. Youth Offending, Care Proceedings etc.) | YES  / NO  Dates of any fixed hearings |
| If the person is “looked after” by the Local Authority, is there a care plan?   * If YES does the care plan propose a referral for a mental health assessment? | YES  / NO  YES  / NO |
| Is the young person on a Child Protection or Child in Need Plan?   * If YES please summarise key people/aspects/steps in the plan | YES  / NO |
| Nationality of young person | Immigration Status of young person |

Other Professionals Involved

|  |  |  |
| --- | --- | --- |
| Are there other Professionals involved with the young person? | | YES  / NO |
| Professional | Name | Contact Details |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Risk Assessment Form *(please complete for all referrals)*

|  |  |  |
| --- | --- | --- |
| Factors | Present? | If yes, please describe |
| Violence to others | YES  / NO |  |
| Cruelty to animals | YES  / NO |  |
| Use / collection / carrying of weapons | YES  / NO |  |
| Self-Neglect | YES  / NO |  |
| Deliberate Self Harm | YES  / NO |  |
| Deliberate Fire Setting | YES  / NO |  |
| Substance Use / Misuse | YES  / NO |  |
| Poor supervision at home | YES  / NO |  |
| Exploitation or abuse?  Physical / emotional / sexual | YES  / NO |  |
| Inappropriate behaviour (e.g. sexual) | YES  / NO |  |
| Psychotic symptoms (e.g. hearing voices) | YES  / NO |  |
| Interfamilial discord | YES  / NO |  |
| Family history of mental problems | YES  / NO |  |
| Family history of self-harm | YES  / NO |  |
| Family history of substance misuse | YES  / NO |  |
| Witness to violence | YES  / NO |  |
| Criminal activity | YES  / NO |  |
| School exclusion/ non-attendance | YES  / NO |  |
| Lack of social support (e.g. family or friends) | YES  / NO |  |
| Poverty / unemployment in family | YES  / NO |  |

Educational Attainment Levels

|  |  |
| --- | --- |
| SATS |  |
| Reading Age |  |
| Spelling Age |  |
| Any Learning Difficulties concerns? |  |
| Is the young person subject to Education, Health and Care (EHC) Plans? | YES  / NO |

Signed Date

Print name

Referrals will be processed between the hours of Monday to Friday between the hours of 9am-5pm.

In the past, referrals to CAMHS have been made via the individual borough teams.

Borough teams contacts details are as follows:

* Barnet (Phone: 0208 702 4500 Email:  [beh-tr.barnetcamhsreferrals@nhs.net](mailto:beh-tr.barnetcamhsreferrals@nhs.net)
* Enfield (Phone: 0208 702 5100) Email:  [beh-tr.enfieldcamhs@nhs.net](mailto:beh-tr.enfieldcamhs@nhs.net)
* Haringey (Phone: 0208 702 3400) Email: [beh-tr.camhsreferral@nhs.net](mailto:beh-tr.camhsreferral@nhs.net)

We will still be taking referrals through the individual borough emails addresses and teams until Monday 1st April 2024.

After Monday 1st April 2024 referrals can only be made via the new number and email (Email: [beh-tr.camhs-spoa@nhs.net](mailto:beh-tr.camhs-spoa@nhs.net) Phone: 0208 702 3111).

After Monday 1st April 2024 please continue to use the individual borough team phone numbers above for non-referral enquiries only and to contact specific teams.