



**Cumbria Child and Adolescent Mental Health Service (CAMHS)**

**Referral Form (NCCCG)**

**INADEQUATELY COMPLETED FORMS AND UNJUSTIFIABLE REQUESTS WILL BE RETURNED TO THE REFERRER**

***PLEASE NOTE IF THE CHILD/YOUNG PERSON IS NOT SEEN AS PART OF THE REFERRAL, IT WILL NOT BE ACCPETED***

***IF THERE ARE IMMEDIATE SAFEGUARDING CONCERNS THEN IT IS THE RESPONSIBILITY OF THE REFERRER TO CONTACT THE SAFEGUARDING HUB.***

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| ***This referral form is for access to services incorporating Primary Mental Health Early Intervention and CAMH Services which are jointly delivered by Cumbria Partnership NHS Foundation Trust and Barnardo’s across Cumbria. Your referral will be reviewed by representatives from both organisations. Onward referral to other agencies will be completed on your behalf where clear consent is included on this form.*** |

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| **PATIENT DETAILS:** | | **Referral Date:** |
| **SURNAME:** | **DOB:** | **PRACTICE:**  **Tel:**  **Fax:**  **Practice code:**  **Registered GP:** |
| **FIRST NAME:** | **AGE:** |
| **NHS NUMBER:** | **GENDER:** |
| **ETHNICITY:** | |
| **RELIGION:** | |
| **ADDRESS:** | |
| **PHONE:**  Home:  Mobile:  Work: | | **INTERPRETER REQUIRED?**  (if yes, state language including signing)  YES  NO |
| **SCHOOL (if known):** | | Is attendance an issue?  DON’T KNOW  YES  NO |
| **DISABILITY** (if yes, provide details): YES  NO | | |
| Is the child/young person “looked after” as defined in the Children’s Act 1989? YES  NO | | |
| Is the child/young person adopted? YES  NO | | |
| Are there safeguarding concerns about the child/young person or family? (if yes, provide details) YES  NO | | |
| Is the child/young person subject to a Child Protection Plan? DON’T KNOW  YES  NO | | |

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| **OTHER SERVICES / PROFESSIONALS INVOLVED (if known):** | | |
| **Name** | **Agency** | **Contact Tel No** |
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| Has an Early Help Assessment been completed? DON’T KNOW  YES  NO | | |

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| **FURTHER HELPFUL INFORMATION:** |
| Does the parent or carer have any known literacy problems? (if yes, provide details) YES  NO |
| Do the parents/guardians have parental responsibility? YES  NO |
| Are the parents/guardians agreeable to the referral? YES  NO |
| Is the child/young person aware of the referral? YES  NO |

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| **REFERRAL DETAILS:** |
| Reason for the referral: |
| When did the problems start? |

Problems

Medication

Allergies

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| **RISK ASSESSMENT:** |
| Are there any issues that place this young person or others at risk? (if yes, provide details) YES  NO |

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| **AGREEMENT TO REFERRAL:** |
| The information on this form will be used to assess the emotional and mental health needs of the referred child/young person. Sometimes we may be able to **re-direct** the referral to a more appropriate service if consent is obtained to share the information with other agencies.  Have the parents/guardians given consent to allow CAMHS to share information as specified above? YES  NO |

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| **REFERRER DETAILS:** | |
| **REFERRER’S NAME:**  **REFERRER’S DESIGNATION:**  **REFERRER’S ORGANISATION:**  **TEL:** | |
| **SIGNATURE:** | **DATE:** |
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**Note to provider: this referral form has been standardised locally in line with the required NHS minimum requirements and guidance from Information Governance. Please email** [**primis@ncic.nhs.uk**](mailto:primis@ncic.nhs.uk) **with any proposed amendments to the form.**

**CEDS Referral Form Triage Prompt Questions**

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| **Does the young person present with a suspected eating disorder?**  *Do they appear to have body image distortion? Are they deliberately attempting to lose weight in an unhelpful way, particularly if weight loss is not clinically indicated? Include an eating disorder diagnosis if this has been given.* |
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| **What is the young person’s current weight and height? And do they have a history of weight loss?** *If so, please give details including the current rate of weight loss.* |
| Single Code Entry: O/E - height  Single Code Entry: O/E - weight |
| **Is the young person currently restricting their food or fluid intake?** I*f yes, please give details. If malnutrition or dehydration is suspected, please include details of any physical health symptoms* |
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| **Does the young person report binging (eating large volumes of food in a short space of time) episodes?** *If yes, please give details.* |
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| **Does the young person report any compensatory behaviours to control or reduce their weight – these include vomiting, laxatives, excessive exercise, diet pills?** *If yes, please give details.* |
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| For any suspected eating disorder, an assessment of physical health risk is essential. Please consider when the young person last saw their GP and consider requesting an urgent appointment to check the following according to Junior MARSIPAN Guidelines: blood biochemistry (full FBC’s, U’s and E’s, Potassium, Magnesium, Phosphate, LFT’s), blood pressure standing and sitting, temperature, pulse rate, weight and height and attaching these results to the referral. Seeks guidance from CEDS clinicians if you are unsure. |

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| **SEND REQUEST TO:** | | **Tel Number** | **Email** |
| **West Cumbria**: | Ann Burrow Thomas Health Centre, South William Street,Workington, Cumbria CA14 2EW | 01900 705800 | [camhs.west1@nhs.net](mailto:camhs.west1@nhs.net) |
| **East Cumbria** | Fairfield Centre, Carleton Clinic, Cumwhinton Drive, Carlisle, Cumbria CA1 3SX | 01228 603017 | [camhs.east1@nhs.net](mailto:camhs.east1@nhs.net) |
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