****CALDERDALE CAMHS (Child & Adolescent Mental Health Service)

# FIRST POINT OF CONTACT (FPoC) REFERRAL FORM

**We encourage referrers to call about crisis/urgent cases, or where suitability is unclear. (01422 300001)**

**You are also able to submit an electronic copy of this referral form at:** [**https://calderdalecamhs.org.uk/how-to-refer/**](https://calderdalecamhs.org.uk/how-to-refer/)

**PLEASE DO NOT POST THIS REFERRAL FORM**

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| **About the Young Person** |
| First Name: | Preferred Name: | Last Name: |
| Address: |
| Postcode: | Gender: |
| Date of birth: | Young Persons Mobile: |
| NHS Number: | Ethnicity: |
| Disability: Y/N | If Y please describe |
| First Language: | Interpreter Required: Y/N | Asylum seeker: Y/N |

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| **Parent / Carer(s)** |
| 1. Relationship to young person:
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| First Name: | Last Name: |
| Telephone Number: | Mobile Number: |
| Address (if different to young person): |
| 1. Relationship to young person:
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| First Name: | Last Name: |
| Telephone Number: | Mobile Number: |
| Address (if different) |
| Should CAMHS write to both addresses: Y/N  |

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| **Siblings** |
| Name: | DOB: | Name: | DOB: |
| Name: | DOB: | Name: | DOB: |
| Past CAMHS involvement: | Y/N | Please provide details |

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| **GP Details**  | **Referrer Details if different to GP** |
| Name: | Name: |
| Job Title: | Job Title: |
| Surgery Address: | Address: |
| Post Code:  | Post Code: | Date: |
| Telephone Number: | Tel Number: |
|  | Email address: |
|  | Signature: |

**Consent:**

**Our normal practice is to contact school staff and other professionals in order to gain a full understanding of the young person’s needs and how they can be met.**

**By submitting this referral you are confirming that the family and/or young person give their consent to CAMHS contacting school and any other relevant agencies.**

**If the family/young person are not happy to give this consent, or if you have any questions or concerns about this process, please provide further details below or contact the FPOC on 01422 300 001 prior to submitting a referral.**

Please provide additional information here:

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| Who holds parental responsibility? |  |
| Have you seen the young person?  | Y/N |
| Is the young person aware of the referral?  | Y/N |
| Is the parent / carer aware of the referral? | Y/N |
| Has the parent / carer consented to the referral? | Y/N |
| Has the person with parental responsibility consented to the referral?  | Y/N |
| If NO then is the young person deemed to be Gillick competent according to the Fraser Guidelines? | Y/N |

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| **Other Agency Involvement** |
| Name of school: |  | Are school aware of the referral? | Y/N |
| School Address: | School Contact: |  |
| Job Tile: |  |
| Is there a CAF / Early Help Plan in place? | Y/N | It Y please attach details and confirm the name of the lead profession: |
| On SEN Support?: | Y/N | If 'Y' please provide further detail below, and forward any relevant documentation. |
| Does the child have a Statement of Special Educational Needs / Education, Health and Care (EHC) Plan or similar? | Y/N | If Y please attach details if available |
| Has there been a past CAMHS involvement? | Y/N/Not Known | If Y please provide details |

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| **Safeguarding:** |
| Has the young person ever been deemed a child in need? |
| Currently |  | Previously |  | Never |  | Not Known |  |
| Has the young person ever been subject to a Child Protection Plan?  |
| Currently |  | Previously |  | Never |  | Not Known |  |
| Does the young person / family have a social worker? |  | Is the young person in the care of the Local Authority?(CLA – Children Looked After Status) |  |
| Social Worker Name: |  | Name Of Local Authority: |  |
| Social worker Tel No: |  | Address of LA: |  |
| Known parental substance misuse |   | LA Telephone Number |  |
| Other people / agencies involved with the young person or family |
| Agency 1 Name: |  | Agency 2 Name: |  |
| Address: |  | Address: |  |

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| **Risk Assessment** | **Yes / No** | **Detail** |
| Current Suicidal Thoughts | Y/N | Please provide full details including severity and frequency in the next section |
| Current Harm to Self | Y/N |
| Current Harm to Others | Y/N |
| Current Self Neglect | Y/N |

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| **REFERRER’S CONCERNS & EXPECTATIONS:** *What is the particular issue you are seeking help or advice about? Please give details of emotional or mental health difficulties, when these started, and how the problem is seen at school and at home, what interventions have been tried etc.*  |
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| **SPECIALIST NEEDS:** *Please identify any risk factors and specialist needs e.g. safeguarding concerns, poor mobility, sensory impairment, learning difficulties, literacy problems, substance misuse, need for interpreter, parental agoraphobia or risk of violence.*  |
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| **YOUNG PERSON’S CONCERNS & EXPECTATIONS:**  |
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| **PARENTAL CONCERNS & EXPECTATIONS:**  |
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| **Referral Reason** - School staff who are referring for an assessment for autism and/or ADHD should download a neuro developmental screening from <https://calderdalecamhs.org.uk/screening-forms/> and submit with this referral |
| ASD | ADHD | ASD & ADHD | Other |
| If “Y” please provide any further relevant information | Please describe |

**Additional Documentation:**

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| --- | --- | --- |
| Do you have any additional documentation that would support this referral?  | Y / N | If ‘YES’ please state and enclose with the referral: |

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| Has this Referral been discussed with MHST?  | Y/N | If ‘YES’ please state who: |

**Please email this referral form (password protected) to:** **firstpointofcontact@calderdalecamhs.org.uk**

**WE NO LONGER ACCEPT POSTAL REFERRALS**

**We’re not able to acknowledge receipt of referrals. We will process the referral as quickly as we can, and we will contact you and the family/young person to update you of the outcome.**

**If you have any questions please call the FPoC on 01422 300 001.**