**CAMHS Referral Form**

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| * Ensure you have read [CAMHS Referral Criteria](https://nhsfife.org/camhs-referral) before completing this form. * Complete the form electronically by clicking on the grey box       to enter text. * Provide as much detailed information about the child/young person as possible. |

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| **1. Child/young person’s details:** | | | | |
| First name |  |  | Address line 1 |  |
| Known as |  | Address line 2 |  |
| Surname |  | Town/City |  |
| Gender | **Click here to enter gender.** | Postcode |  |
| Date of birth |  | Phone number |  |
| CHI number |  | Email address |  |

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| **2. When did you last have contact with the child/young person?** | **Click here to enter a date.** |

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| **3. Consent:** | |
| Under 12 – Parent/carer has given consent for this referral | **Click here to enter yes or no.** |
| 12 and over – Young person has given consent for this referral | **Click here to enter yes or no.** |

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| Has consent been given for information to be shared with other agencies? | **Click here to enter yes or no.** |
| Has consent been given for onward referral if not suitable for CAMHS? | **Click here to enter yes or no.** |
| If no, please give details: | |

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| **4. Who have you consulted with prior to making this referral?** | |
| Team around the child | Please give details: |
| CAMHS Primary Mental Health Workers | Please give details: |
| Someone else | Please give details: |

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| **5. Please describe the child/young person’s living arrangements, and any formal care arrangements:** |
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| **6. Please give details of everyone in the home:** | | |
| Name | Age | Relationship to the child/young person |
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| Any other people in the home: | | |
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| **7. Please give details of any Child Protection issues, past or present:** |
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| **8. Do you have any of the following safety concerns about the child/young person?** | |
| Suicidal thoughts | Please give details: |
| Risk of harm to self | Please give details: |
| Risk of harm to others | Please give details: |
| Risk of self neglect | Please give details: |
| Other safety issues | Please give details: |

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| **9. Please describe the reason for referral, including:**   * **how severe the difficulties are** * **when they started** * **how often they occur** * **how they impact on day to day life** * **any variance across settings (e.g. home, school)** |
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| **10. Please give details of Services previously accessed regarding the child/young person’s emotional wellbeing:** | | | |
| Service | Intervention | Outcome | Date |
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| Any other Services previously accessed: | | | |
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| **11. Please give details of any relevant past or present issues relating to:** | |
| 1. General health and any medical history including assessments, diagnoses, interventions and/or specific difficulties or disabilities |  |
| 1. Concerns about developmental issues and progress at nursery/school (*e.g.* *developmental delay, specific language impairment, learning difficulty/disability*) |  |
| 1. Significant life events (*e.g. loss, trauma, bereavement*) |  |
| 1. Any other factors impacting on the child/young person’s wellbeing |  |

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| **12. What are the specific concerns or expectations of the child/young person or parent/carer following this referral?** |
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| **13. Referrer’s details:** | |  | **14. GP’s details:** | |
| Full name |  |  | Full name |  |
| Job title |  | Practice name |  |
| Organisation |  | Practice number |  |
| Address |  | Address |  |
| Phone number |  | Phone number |  |
| Email address |  | Email address |  |

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| **15. Details of Professionals currently involved with the child/young person:** | | | | |
| **Named Person** | |  | **Lead Professional (if applicable)** | |
| Full name |  |  | Full name |  |
| Job title |  | Job title |  |
| Organisation |  | Organisation |  |
| Address |  | Address |  |
| Phone number |  | Phone number |  |
| Email address |  | Email address |  |

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| **Education** | |
| Name of nursery/school/college |  |
| Full name of main contact/guidance teacher |  |
| Phone number |  |
| Email address |  |

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| **Other Service/Professional** | |  | **Other Service/Professional** | |
| Full name |  |  | Full name |  |
| Job title |  | Job title |  |
| Organisation |  | Organisation |  |
| Phone number |  | Phone number |  |
| Email address |  | Email address |  |

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| **Other Service/Professional** | |  | **Other Service/Professional** | |
| Full name |  |  | Full name |  |
| Job title |  | Job title |  |
| Organisation |  | Organisation |  |
| Phone number |  | Phone number |  |
| Email address |  | Email address |  |

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| **Any other Service/Professional(s)** |  |

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| **16. Parent/carer contact details:** | | |
|  | **Parent/carer 1** | **Parent/carer 2** |
| First name |  |  |
| Surname |  |  |
| Address (if different to child/young person) |  |  |
| Relationship to child/young person |  |  |
| Phone number |  |  |
| Email address |  |  |

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| **17. Please provide a mobile phone number for text reminders about appointments:** |
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| **18. Please give details of any support needs/arrangements required to meet with the child/young person and their family (*e.g. interpreter*):** |
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| **19. Is there any other relevant information?** |
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| **20. Date form completed:** | **Click here to enter a date.** |

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| * **Please email your completed Referral Form to:** [**Fife.camhsreferrals@nhs.scot**](mailto:Fife.camhsreferrals@nhs.scot) * This email address must only be used to submit CAMHS Referral Forms. |