



**East Midlands Forensic CAMHS Referral Form**

Please complete as fully as possible and send to [FCAMHSEastMidlands@nottshc.nhs.uk](mailto:FCAMHSEastMidlands@nottshc.nhs.uk)

**Date of referral** Click to select a date. **Date Received**  Click to select a date.

**Young Person’s Details**

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| --- | --- | --- | --- | --- | --- | --- |
| Name | | Preferred name | | Gender | | |
|  | |  | | M  F | | |
| Date of Birth | Age at referral | | NHS No. | | | Rio Number if known |
|  | Please select | |  | | |  |
| Nationality | | Religion | | | Ethnicity | |
|  | |  | | |  | |

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| --- | --- |
| Home address | Address at time of referral (if different) |
| Phone number: | Phone number: |
| Next of Kin/ Carer details | GP’s details |
| Name  Address  Phone number  Relationship to young person? | Name  Address  Phone number  Aware of referral? Yes No |

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| --- | --- |
| Referrer’s details | Local CAMHS worker |
| Name:  Profession/designation:  Address:  Telephone Number:  Email address:  Sector Please select  If ‘other’ please specify | Name:  Profession/designation:  Address:  Telephone Number:  Email address: |

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| **Consent** | | | | | |
| Has the young person been informed of this referral? | | Yes |  | No |  |
| Has the parent or other person with parental responsibility been informed of this referral? | | Yes |  | No |  |
| Has consent been obtained for this referral? | | Yes |  | No |  |
| Consent means the young person is aware and agrees that: | | | | | |
| 1. Information about them will be shared with FCAMHS | | Agree |  | Not Agree |  |
| 1. Information about them may be discussed with multiagency professionals | | Agree |  | Not Agree |  |
| 1. That FCAMHS will send a written summary to multiagency professionals and their GP | | Agree |  | Not Agree |  |
| Name of person giving consent  (relationship to the young person if not the young person) |  | | | | |
| If consent has not been given, please state the reason why the referral should be considered without consent  (e.g. particular safeguarding / imminent risk concerns) |  | | | | |
| **Please note, by submitting this referral, you are also confirming that you have followed your local consent policies. This includes gaining the relevant consent for referring to our service, and the sharing of appropriate information across agencies involved.** | | | | | |

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| Other agencies involved at time of referral? | | | | | |
| CAMHS |  | Social Care |  | YOS |  |
| Education |  | Police |  | None |  |
| Other  Please specify | | | | | |

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| Details of other professionals working with the young person | | | |
| Name:  Profession/designation:  Address:  Telephone Number:  Email address: | Name:  Profession/designation:  Address:  Telephone Number:  Email address: | | |
| Name:  Profession/designation:  Address:  Telephone Number:  Email address: | Name:  Profession/designation:  Address:  Telephone Number:  Email address: | | |
| Previous contact | | Yes | No |
| Has the young person had previous contact with CAMHS? | |  |  |
| Has the young person had previous contact Forensic CAMHS? | |  |  |

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| Living arrangements at time of referral | Social care status |
| Please select  If other, please specify | Please select  If other, please specify |
| Describe living conditions at time of referral: | |

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| **ACES** | Yes | No | Don’t know |
| Has the young person ever lived with a parent/ caregiver who went to jail/ prison? |  |  |  |
| Has the young person ever felt unsupported, unloved and/or unprotected? |  |  |  |
| Has the young person ever lived with a parent/ caregiver who had mental health issues? |  |  |  |
| Has a parent/ caregiver ever insulted, humiliated or put down the young person? |  |  |  |
| Has the young person’s biological parent or any caregiver ever had a problem with too much alcohol, street drugs or prescription medication use? |  |  |  |
| Has the young person ever lacked appropriate care by any caregiver? |  |  |  |
| Has the young person ever seen or heard a parent/ caregiver being screamed at, sworn at, insulted or humiliated by another adult? |  |  |  |
| Has the young person ever seen or heard a parent/ caregiver being slapped, kicked, punched, beaten up or hurt with a weapon? |  |  |  |
| Has any adult in young person’s household often or very often grabbed, slapped or thrown something at the young person? |  |  |  |
| Has any adult in the young person’s household ever hit the young person so hard that the young person had marks or was injured? |  |  |  |
| Has any adult in the household ever threatened the young person or acted in a way that made the young person afraid that they might be hurt? |  |  |  |
| Has the young person ever experienced any sexual abuse |  |  |  |
| Has there ever been significant changes in the relationship status of the young person’s caregivers? |  |  |  |
| Has the young person ever seen, heard, or been victim of violence in their neighbourhood, community or school? |  |  |  |
| Has the young person experienced discrimination? |  |  |  |
| Has the young person ever had problems with housing? |  |  |  |
| Has there ever been a time when the young person has been short of food? |  |  |  |
| Has the young person ever been separated from their parent or caregiver due to foster care or immigration? |  |  |  |
| Has the young person ever lived with a parent or caregiver who had a serious physical illness or disability? |  |  |  |
| Has the young person ever lived with a parent or care giver who died? |  |  |  |

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| Education status | | | Criminal justice status |
| Please select.  If other, please specify: | | | Please select.  If other, please specify: |
| Is there an EHCP | Yes | No |

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| Primary mental health diagnosis | Primary diagnosis (check one) | Comorbid Diagnosis  (check all relevant) | |
| ADHD |  |  | |
| Attachment disorder |  |  | |
| Anxiety |  |  | |
| Autistic Spectrum Disorder |  |  | |
| Conduct disorders (without clear borderline traits) |  |  | |
| Conduct disorder with clear borderline traits |  |  | |
| Depression |  |  | |
| Developmental Trauma |  |  | |
| Learning disability or significant difficulties |  |  | |
| Post-traumatic stress or allied disorder |  |  | |
| Psychosis |  |  | |
| Sensory processing disorder |  |  | |
| Other (specify): |  |  | |
| Emotional Dysregulation |  |  | |
| Selective mutism |  |  | |
| Developmental Language Disorder |  |  | |
| Acquired brain injury |  |  | |
| Anything not listed |  |  | |
| No diagnosis |  |  | |
| Diagnosis not possible/ available |  |  | |
| What medicine has been prescribed, if any? | | | |
| Who has prescribed the medicine, if known? | | | |
| Is the young person under the Mental Health Act? | | Yes | No |
| Is there any substance misuse?  If so, Please give details | | Yes | No |

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| Are there any other relevant queried diagnoses, signs or symptoms? |
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| Language and communication needs of the young person | Yes | No | Don’t know |
| Does the young person have difficulties listening to, remembering or understanding what you say? |  |  |  |
| Does the young person have difficulties finding the right words or give enough information when speaking? |  |  |  |
| Does the young person have difficulties interacting with others (poor social skills)? |  |  |  |
| Does the young person have a stammer or use unclear speech? |  |  |  |
| Does the young person have difficulties understanding written information including leaflets or letters? |  |  |  |
| Is there any other information regarding the young person’s communication that you would like to tell us about?  If so, Please give details | | | |

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| Occupational therapy | Yes | No | Don’t know |
| Are there any concerns that may require occupational therapy input – including but not limited to support with independent living, maintaining routine, concerns with sensory needs or difficulties with motivation? |  |  |  |
| If so, Please give details | | | |

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| Reason for referral |
| \* Please select a reason  If you have selected ‘multiple’ or ‘other’, please give details  Please tell us full details of specific incidents of concern, including dates: |

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| Referrer’s anticipated outcome  **\*\*This section must be completed before referral can be opened\*\*** |
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**Please attach any supporting documents from the network**