Mental Health Support Team Referral Form

**To be completed by Education Staff/Mental Health Lead*

Assessment and intervention will be carried out by practitioners who are engaged in an active supervision programme, for the purpose of their learning and assessment, intervention sessions may be recorded.

To receive input from the CAMHS Mental Health Support Team, we require the signed consent of the young person and their parent/carer.
If you are unable to obtain signed consent from the young person/parent/carer please ensure that you have discussed the referral and obtained verbal consent from the young person/parent/carer and clearly document this in the section below

Child/Young Person: ……

Parent/Carer: ……..

Do we have permission from the young person to liaise with the parent/carer regarding this referral if required?

Please circle as appropriate: Yes / No

Do we have permission from the young person/Parent/Carer to liaise with relevant agencies if required?

Please circle as appropriate: Yes / No

Do we have permission from the young person to leave voicemails and/or sent text messages?

Please circle as appropriate:

Voicemail Messages: Yes / No

Text Messages: Yes / No

Preferred contact number/email:_____

By consenting to this referral, please note that, upon screening, it may be appropriate for your referral to be passed to another team within the wider CAMHS Service.

CHILD/YOUNG PERSON DETAILS

Name:		NHS Number:	
Address: Postcode:		Date of Birth:	
		School/College:	
		Year:	

Previous Names / Alias:		Religion:	
GP name and address:		Ethnic Origin:	
		Nationality:	
Contact Tel. for young person:		First language:	
Contact Email for young person:		Gender:	

PARENT/ CARER

Name	Relationship	Address (if different to child)	Contact Phone Number / Email Address
			Phone:
			Email:

Key Presenting Issue	Yes	No
Mild to moderate Anxiety		
Mild to Moderate Worry		
Mild to Moderate Low Mood		
Mild to Moderate behaviour difficulties		

Key Presenting Issue	Yes	No
OCD		
PTSD		
Social Anxiety		
Phobia		

Existing Physical Health Conditions

……
……
……

Has this child/YP ever talked to another "professional" about their problem(s)? **Yes/No**
If **yes**, please describe who this was below (Examples include teacher, social worker, nurse, doctor, youth worker, CAMHS worker or other professional)

……
……
……
……
……

Who is currently involved with the child /YP

.....
.....
.....
.....
.....

	Yes	No
Looked After Child		
Education Health and Care Plan		
Special Education Needs and Disabilities		
Interpreter Required		
Pupil Premium		
Young Carer		
Safeguarding/Risk/Concerns		

If you have ticked any of the above, please use the space below to provide as much information as possible especially with Safeguarding/Risk concerns:

Please describe the impact that the difficulties ticked above is having on the child/YP and/or their family.

How does the young person/family feel the service would benefit them?

Name and role of referrer & email address:	
Date of referral:	
Referrer contact number: Microsoft Teams Email	
Name/Email address of school staff member to contact to make an appointment	

School Mental Health Lead to forward completed forms to CAMHS SPA:
SPAReferrals@nottshc.nhs.uk

Please indicate in the email subject that the referral is for the Mental Health Support Team.

Please be aware that incomplete referrals will not be processed and will cause a delay in the child/young person receiving support- so please ensure you complete all areas of the form.

Contact number for SPA: 0115 8542299

Contact number for MHST: 0115 8760167
Email address: CAMHSMHSTTrailblazer1@nottshc.nhs.uk for queries only

If you would like to include any parental views, please do so on a separate sheet and attach to this form.