**SANDWELL CAMHS**

**SINGLE POINT OF ACCESS - REFERRAL FORM**

*Please note that by referring to SPA you are referring to Sandwell Specialist CAMHS and any agencies we are commissioned to work with. Information may be shared with all partnership organisations - young people will be* *referred or signposted as* *appropriate*

 CAMHS Single Point of Access (SPA)

48 Lodge Road

West Bromwich

B70 8NY

Tel: 0121 612 6620

Email: bchft.sandwellspa@nhs.net

Website: [www.BlackCountryMinds.com](http://www.BlackCountryMinds.com)

In the event of any referral queries, we are happy to help, please contact our dedicated SPA team on 0121 612 6620 or email [bchft.sandwellspa@nhs.net](file:///%5C%5CBob%5CUser%24%5CDAMoreton%5C%23%23%23%23%23%23SPA%5Cbchft.sandwellspa%40nhs.net). Please note - **ALL FIELDS ARE MANDATORY** unless otherwise specified and incomplete referral forms will be returned for your completion.

**SECTION A – Child/Young Person’s Referral Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name: |  | Date of Birth: |  | Gender: [ ] Male [ ]  Female |
| Full Address: Postcode: |  | NHS Number: |  |
| Contact Number(s): |  |
| Ethnicity: |  | School/College: |  |
| Parent/Carer Name Contact Number(s):(if different): |  | Child/Young Person’s GP Details: |  |

**SECTION B – Referrer’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Service/Department: |  |
| Full Address: Postcode: |  | Job Title/Profession: |  |
| Email Address: |  |
| Contact Number(s): |  |

**SECTION C – General Referral Information**

**Consent to referral**

Is the child/young person aware of this CAMHS referral and is consent given? [ ] Yes [ ]  No If no, details:

Is the parent/carer aware of this CAMHS referral and is consent given? [ ] Yes [ ]  No If no, details:

Has the child/young person previously been referred to CAMHS? [ ] Yes [ ]  No [ ]  Do not know

**Consent to share information**

In the case that your referral is reviewed and it is determined that CAMHS is not the appropriate service, we are able to forward your referral to the service that we feel would best suit your needs.  The services that we can forward your referral to may be within other NHS Trusts, Local Authority organisations or other 3rd party organisations such as charitable or voluntary sector services.

To enable us to ensure that you have access to the most appropriate service, we require your consent to allow us to forward your referral onto the alternative services.  Can you please identify below if you are happy for us to forward your referral onto a third party.

**I confirm that I am happy for you to forward my referral onto the following organisations if the services that they provide are more appropriate for my needs *(tick all that apply)*:**

[ ]  Other NHS Services Print:

[ ]  Local Authority Services Sign:

[ ]  Other 3rd Party Service providers Date:

**Needs**

Does the child/young person have a Learning Disability? [ ] Yes [ ]  No If yes, severity:

Does the child/young person have any physical/mental health conditions? [ ] Yes [ ]  No If yes, details:

Is the child/young person currently prescribed any medication? [ ] Yes [ ]  No If yes, affix summary:

Is an interpreter required for child/young person or parent/carer? [ ] Yes [ ]  No If yes, details:

Will the parent/carer be able to understand the correspondence that we send? [ ] Yes [ ]  No If no, details:

Are there any barriers that may prevent attendance at initial appointment? [ ] Yes [ ]  No If yes, details:

**Legal Status**

Tick any of the following that apply to the child/young person and complete details (see full referral criteria for further details):

[ ]  Child or Young Person in Care\* Details:

[ ]  Subject to a Child Protection Plan\* Details:

[ ]  Subject to a Child in Need Plan\* Details:

[ ]  Adopted\* Details:

If a box above is ticked, please confirm that the Social Worker is aware of and supports the CAMHS referral? [ ]  Yes

|  |
| --- |
| Social Worker Details (\*must be completed if a box in the above section is ticked) |
| Name: |  |
| Address/Base: |   |
| Contact Number(s): |  |

**Professional Network**

Please tick and name other professionals currently involved with the child/young person (or family if relevant):

[ ]  Paediatrician: [ ]  Educational Psychologist:

[ ]  Social Worker: [ ]  School Nurse:

[ ]  Occupational Therapist: [ ]  Speech & Language Therapist:

[ ]  Health Visitor: [ ]  Dietitian:

[ ]  Counsellor: [ ]  Other:

**SECTION D – Presenting Difficulty Referral Information**

|  |
| --- |
| Please describe your reasons for referring the child/young person to BEAM/CAMHS(additional information can be attached) |
|  |
| Please outline any known risk issues (social, education or health) and state if these are current or historic:(In the event of self-harm and/or suicidal thinking, please provide as much information as possible)(In the event of any immediate safeguarding concerns, information will be shared with the appropriate agencies) |
|  |

Do you consider this referral to be urgent? [ ] Yes [ ]  No

|  |
| --- |
| If yes, please give clear reasons on the basis of the child/young person’s mental health: |
|  |

|  |
| --- |
| Please list any supporting information that accompanies this referral form: |
|  |

Has this referral been verbally discussed with a member of the CAMHS SPA Team? [ ] Yes [ ]  No If yes, date:

Note to referrers

* The quality of the information you provide will help us to process and prioritise this referral more effectively
* Where appropriate, we will signpost or refer young people onto alternative services, if this is not possible, you will be advised

|  |  |
| --- | --- |
| Referrer’s Signature (initial for electronic): |  |
| Date: |  |