West London NHS Trust

Child and Adolescent Mental Health Service (CAMHS)

☐ Ealing CAMHS	☐ Hammersmith & Fulham CAMHS	☐ Hounslow CAMHS
1 Armstrong Way Southall Middlesex UB2 4SA Tel: 020 8354 8160 E- mail referrals to: wlm-tr.EalingCamhs@nhs.net	48 Glenthorne Road Hammersmith London W6 0LS Tel: 020 8483 1979 E-mail referral to: wlm-tr.hfcamhs@nhs.net	Heart of Hounslow Centre for Health 92 Bath Road Hounslow TW3 3EL Tel: 020 8483 2050 E-mail referrals to: wlm-tr.hounslowcamhs@nhs.net

CAMHS Referral form for use from July 2021

Please email this completed form to your local CAMHS Service. Faxes are no longer accepted.

We are required to register the full demographic details (including area of residency, GP details and NHS number) of all referrals. Please include this information in your referral otherwise we will need to return this form to you prior to triage.

Date of Referral		
PRIORITY (see separate guidance)	☐ Routine	☐ Urgent

Child/Young Person (Patient) Details		**Parent/Carer/Guardian Details**	
First Name		**Name of parent/carer**	
Surname		**Address**	
NHS No		**Home or Mobile Tel**	
DOB		**Email**	
Gender		**Name of parent/carer**	
Ethnicity		**Address**	

Child/Young Person (Patient) Details		Parent/Carer/Guardian Details	
Address		**Home or Mobile Tel**	
Area of Residency		**Email**	
Home Tel		**Name of Carer/ Guardian** *if applicable*	
Mobile Tel		**Address** *if applicable*	
Email		**Home or Mobile Tel** *if applicable*	
		Email *if applicable*	
Status	☐Single ☐Other ☐Not Specified	**Main residence of child/young person**	
Main Language spoken		**Main language spoken by family**	
Learning Disability	☐No ☐Yes	**Learning Disability**	☐No ☐Yes -
Physical Disability	☐No ☐Yes	**Physical Disability**	☐No ☐Yes
Interpreter	☐No ☐Yes	**Interpreter**	☐No ☐Yes
GP Name if not referrer		**Who holds parental responsibility?** *(give details e.g. parent/carer/Local Authority (LAC) include name and contact details if not already shown above)*	
GP Phone No			
GP Address if not referrer			
GP admin email address ***if known***			
School/College *if applicable*			
School/College Address			
School/College Phone No			
Special School	☐No ☐Yes		

Referrer Details			
Name		**Organisation code** *if applicable*	
Role/Title		**Telephone No**	
Organisation		**Email admin (NHS or egress)**	
Address			

Consent – if this section is not completed fully, the referral will be returned to you prior to triage		
Has the child/young person/family had previous involvement with this or any other CAMHS	☐Yes	☐No
Do the parents/carer/guardians (who have parental responsibility) consent to this referral to CAMHS	☐Yes	☐No
Do the parents/carer/guardians (who have parental responsibility) consent to this referral to CAMHS being shared with another more appropriate NHS or Local Authority Service? This includes being sent to another Trust such as CNWL.	☐Yes	☐No
If no, are the parents/carer/guardians (who have parental responsibility) aware of this referral?	☐Yes	☐No
If the young person is 16 years and over, does the young person consent to this referral to CAMHS	☐Yes	☐NA
If the young person is 16 years and over, does the young person consent to this referral to CAMHS being shared with another more appropriate NHS or Local Authority Service? This includes being sent to another Trust such as CNWL.	☐Yes	☐NA
If the young person is 16 years and over, does the young person consent to this referral being shared with their parents/carer/guardians?	☐Yes	☐NA
Are there any other matters such as culture, language, illness, religion or disability that we may need to consider when getting in touch. If you have indicated that there is a learning or physical disability affecting the Child/Young Person or family member, please specify here:	☐Yes Give Details:	☐No

Reason for Referral	
Reason for Referral *(Please specify why you think a CAMHS assessment is required and what you wish the service to do)*	
Main Concerns – Symptoms *(Give details about onset, duration, frequency, severity)*	
Settings (Home, School and Community) *(Neurodevelopmental disorders and other mental health conditions are pervasive across settings – home, school and community. Give details in relation to different settings)*	
Impact, Distress and Impairment *(Give details of child development, family life, social life, learning/academic performance)*	
Risk /Safeguarding Concerns	

Is the family known to Children's Social Services?	☐No ☐Yes ☐Unsure If yes give details:
Does the child have an Education, Health & Care Plan (EHCP), Child Protection (CP) Plan, Child in Need (CIN) Plan?	☐EHCP ☐CP ☐CIN
Is the child/young person a Looked After Child (LAC)	☐No ☐Yes ☐Unsure
Is the child/young person/family currently involved in Legal Proceedings relating to the child/young person?	☐No ☐Yes ☐Unsure If yes give details:
Are you aware of any domestic violence or abuse issues in this family?	☐No ☐Yes ☐Unsure If yes give details:
Are you aware of any drug or alcohol issues in this family?	☐No ☐Yes ☐Unsure If yes give details:
Medical History *(Give sufficient details to rule out organic conditions)*	
Current Acute Medication in last month	
Current Repeat Medication	
Allergies & Sensitivities	
Interventions Previously Tried (Individual and/or family) *(Give details of school, universal/primary/secondary interventions)*	
Other Professionals Involved	

Other Professionals Involved and Reports *(Give details of other agencies involved now or in the past with the child/young person and family)*	**Agency Name**	**Named Worker**	**Address**	**Tel No**

Is the child/young person on a waiting list for a service?	☐No ☐Yes ☐Unsure If yes give details:
Relevant reports attached	☐No ☐Yes

	If No, please give reasons as this may significantly delay the processing of this referral: Please state which reports are attached