**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 |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| 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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|       |

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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**
* This email address must only be used to submit CAMHS Referral Forms.
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