

Child & Adolescent Mental Health Services**PROFESSIONAL REFERRAL FORM****Child /Young Person's Details**

NHS No. _____

First Name _____

Address _____

Post Code _____

Tel. No _____

Mobile No _____

Name of School _____

GP Name _____

Practice _____

Contact No. _____

Date Referred: _____**Referral From**

Name _____

Designation _____

Address _____

Postcode _____

Tel No. _____

Email Add _____

Person with Parental Responsibility

Title _____

First Name _____

Address _____

Postcode _____

Family Name _____

Date of Birth _____

Sex Male Female

Ethnicity: _____

Religion: _____

Any Physical access needs due to disability? Yes No Does the family need an interpreter? Yes No

If YES please specify which language: _____

Child Protection Registration?

Current Previous None **Referral To :- (please indicate either)****Child & Family Consultation Service** **Primary Mental Health Team**

Raphael House

Pettits Lane

Romford, Essex

RM1 4HP

Tel. No. 0844 600 1124 (CFCS)

0844 600 1201 *6609 (PMHT)

Fax. No. 0844 493 0280

For Office Use Only

CAMHS Number _____

Received Date ___ / ___ / ___

Priority E U S R

Family Name _____

Relationship _____

Day Tel No. _____

Eve Tel No. _____

Mobile No. _____

Other Professionals Known to be Involved

None	<input type="checkbox"/>	CPN	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>
Psychotherapist	<input type="checkbox"/>	Nursery	<input type="checkbox"/>	Speech Therapist	<input type="checkbox"/>
Educational Psychologist	<input type="checkbox"/>	Other Therapies	<input type="checkbox"/>	Educational Welfare Officer	<input type="checkbox"/>
Court	<input type="checkbox"/>	Police	<input type="checkbox"/>	School Nurse / Doctor	<input type="checkbox"/>
Health Visitor	<input type="checkbox"/>	SENCO	<input type="checkbox"/>	Hospital/Community Doctor	<input type="checkbox"/>
GP	<input type="checkbox"/>	YOTS	<input type="checkbox"/>	Others (specify)	<input type="checkbox"/>

Description of Presenting Problem (reason for referral)**Optional:** include any supporting reports / assessments you feel would be helpful**We would find the following helpful to know:**

1. When problem started:
2. Any recent changes in family circumstances / member:
3. Anything which helps / worsens problem:
4. What has already been tried:
5. Any Child Protection issues:

Has the referral been discussed with the parent / carer? Yes [] No []

Has the referral been discussed with the child / young person? Yes [] No []

Is there Parental Consent for further inquiry to other agencies? Yes [] No []

Referrer's Signature _____