SINGLE POINT OF ACCESS
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES REFERRAL FORM

Providing detailed information on this form helps us to quickly allocate to the most appropriate agency/service/team and prioritise where necessary. If there is insufficient information we may return the referral to you, which will result in delay for the family. Please telephone if you would like to discuss the case before making the referral. Please also phone for more information on our consultation service to professionals. Telephone 0151 293 3662 or 0151 252 5225.

1. Details of the Child or young person

Name:

Ethnicity:

Gender:

Date of Birth:

NHS Number:

Address:

Previous Surname:

Main Telephone Number:

Post Code:

Other Telephone Number:

Parent(s) / Carer's name:

Who has parental responsibility:

Parent's address if different from child:

Address:

Parent's Contact Number:

Parent's alternative number:

Post Code:

School:

Year group:

Key School Contact:

Is there a statement of educational need:

Child In Need

Is there a CAF (if yes please enclose)

Legal Status

Care of Parent

Care of Local Authority:

Liverpool Sefton Other

Section 20 Voluntary Accommodated

Full Care Order

Interim Care Order

Care Order places at home

Child Protection Plan

Other Carer - Give details

2. Professionals Involved

Please list all professionals with current contact details (phone and e-mail)

3. Consent

	Yes	No
Has the referrer met with the child or young person?		
Has child / young person given consent to referral?		
Has parent / guardian given consent to referral?		
Has the parent/young person consented to transfer of referral information to a CAMHS partnership agency if assessed as more appropriate for their needs		

Young person's signature

Parent signature

Referrals can only be accepted if the referrer has met with the child, who has given their consent if Frazer competent and full parental consent is obtained . If consent is not possible please phone to discuss.

SINGLE POINT OF ACCESS
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES REFERRAL FORM

4. GP Details (if not referrer)

Address:		Doctor	
		telephone Number	
Post Code:			

5a. Reason for Referral

Please give a detailed *description of the child/young person's emotional/behavioural or mental health difficulties. Please indicate the severity and frequency of the difficulties and behaviours and how these impact on the young person and their family.*

5b.

What help and outcomes are the family or professional expecting from the CAMHS referral.

5c.

Please list the impact the child or young persons diffculities are having on their education or nursery placement.

5d. Duration of the identified problem months

6. Adaptations for appointment (Does the child require adaptations for attending appointments? E.g. venue, time, translation.)

7. Family Composition

Please detail all relevant family members.

Name	Age	Relationship with child	Currently live with Child?

8a. What interventions have the family already receiv

8b. What was the outcome?

SINGLE POINT OF ACCESS
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES REFERRAL FORM

Thank you for completing the form

All referrals are seen by an experienced clinician at referral. Specialist CAMHS may assume duty of care re: Mental Health Issues at assessment. However referrals, once reviewed, may be signposted to CAMHS partner agencies for appropriate on-going intervention. We will inform the referrer of our decision to do this and expect the referrer to continue to hold duty of care during this transition.

Please return the form to
Fax: 0151 293 3698

Post: Single Point of Access
Alder Hey, Mulberry House,
Eaton Road,
Liverpool,
L12 2AP

Has the possibility of the referral being signposted to one of our partner agencies been discussed with the family ? Yes No

Referrer Details

Name		Profession	
Address:		Telephone number	
		Fax Number	
Post Code:		E-mail address	
Date:		Referrer Signature	

End of Referral Form - Please attach any further documentation here