

# CAMHS Gloucestershire Referral Request Form

## General Information

All referrals into CAMHS Service are accessed only during office hours 9-5 Monday to Friday.  
**CAMHS Practitioner Advice Line:** We also provide a consultation service for professionals considering a referral to CAMHS. The purpose of consultations is to ensure that the young person is signposted to the appropriate service for their needs. To speak with CAMHS Practitioner Advice Line call: **01452 894272**  
**Urgent Referrals:** If the referral is urgent, please call CAMHS Practitioner Advice Line on 01452 894272 who will be able to advise you about what to do.  
**Crisis referrals:** If you believe the life of a child or young person is at immediate risk, please dial 999 straight away or go to the nearest Accident & Emergency department.  
**Referrals to GHC Eating Disorder Service** can be made by completing this online referral form: Eating Disorders Referral Form > Gloucestershire Health and Care NHS Foundation Trust (ghc.nhs.uk)  
**Other useful web resources:**  
 Young Gloucestershire - Home (youngglos.org.uk)  
 Tic+ – Counselling services in Gloucestershire (ticplus.org.uk)

## Consent

<b>Consent for referral to service*</b>  <i>No referral can be accepted without the consent of the child or parent/guardian. Please select applicable consent.</i>	<b>Consent given by:</b>  <input type="checkbox"/> Child <input type="checkbox"/> Parent/Carer
<b>Consent to share with other agencies*</b>	<b>Does child/young person or parent/carer agree to information being shared between agencies?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No

## Referrer details\*

Name and Position:	Address:
Telephone number:	
Decision to Refer Date:	Practice Safe Haven Email:

## About the child/ Young Person\*

Young person's name:	Date of birth:
Preferred name:	Family name if different to theirs?
Preferred pronouns:	Address:
<input type="checkbox"/> she/her/hers <input type="checkbox"/> he/him/his <input type="checkbox"/> they/them/their	
NHS Number:	Gender:
Ethnicity:	Ethnic category - 2011 census England and Wales
Translator required:	Language:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sign interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Capacity concerns? e.g. has learning disabilities?	Mobility concerns:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a carer:	Is a Carer:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Young Person in care/special guardianship/safeguarding concerns?	
<input type="checkbox"/> Yes, Child in Care <input type="checkbox"/> Yes, Special Guardianship <input type="checkbox"/> Yes, Safeguarding Concerns <input type="checkbox"/> No	
Has the young person been a resident of the UK	Name of the education setting or
<input type="checkbox"/> Yes <input type="checkbox"/> No	

for 6 months or longer?

NEET/Homeschooled  
Oldham and Knight SEND  
School Tewksbury

### Child/Young Person Contact Details\*

Preferred Contact number:	Preferred contact number name: <i>(if parent/carer – specify who the phone number belongs to)</i>
Alternative contact number:	Alternative contact number name:
Preferred Email:	Preferred Email name: <i>(if parent/carer – specify who the phone number belongs to)</i>

### About the principal parents/main carers\*

Does the child/young person have a main carer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Full Name:	
Relationship:		Parental responsibility:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone number:		Email:	
Is there any additional information you would like to add?			

### Reason for referral\*

Please let us know why you are making this referral, including details of any previous or current mental health problems.  
The more information you include, the better we can decide on how best to help the young person.

Please describe any mental health difficulties they might be having e.g. worries, sadness, anger, changeable moods or feelings, self-harm.	How long has this been affecting them?
	<input type="checkbox"/> Less than a month <input type="checkbox"/> 1-5 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> Over a year
What self-help or interventions have already been tried (for example TIC+ or private counselling)?	
What impact have these had on them, and have they had any impact on their family, schoolwork or friends?	
Has anything happened recently to make them seek help at this time (for example big family events or illnesses)?	
Is there any further information that you/they think we should know?	
What support are the family/young person wanting from CAMHS?	

### Other professionals\*

Is the young person currently working with, or have they worked with, any other agencies, people or organisations, including their school? *(Please list all agencies involved below)*  Yes  No

1 <sup>st</sup> agency or individual name:		Start date (best guess):	
Are you happy for us to get in contact with this agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone number:		Contact email:	
Please give details of length and nature of their support (e.g. 6 sessions with TIC+ online)			

2 <sup>nd</sup> agency or individual name:		Start date (best guess):	
Are you happy for us to get in contact with this agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone number:		Contact email:	
Please give details of length and nature of their support (e.g. 6 sessions with TIC+ online)			

3 <sup>rd</sup> agency or individual name:		Start date (best guess):	
Are you happy for us to get in contact with this agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone number:		Contact email:	
Please give details of length and nature of their support (e.g. 6 sessions with TIC+ online)			

## GP medical information

### Medication:

Acutes  
Repeats

### Medical History:

### Allergies:

### Relevant Family History:

### Alcohol status:

### Other:

## Supporting Information

Please email separately any additional information you feel is relevant to this referral. Please email these to [CAMHSreferrals@ghc.nhs.uk](mailto:CAMHSreferrals@ghc.nhs.uk)