CAMHS Service Request

Patient Details

Date of Referral

Has the family/young person agreed to this referral?

○ Yes ○ No

Who has given consent for this referral?

Full Legal Name

Preferred name (if different)

D.O.B

Sex assigned at Birth

Address

Postcode

Patient Phone / Mobile

Carer Phone / Mobile

NHS Number

Patient email

Interpreter Required?

○ Yes ○ No

If required, what language

Does the patient have any other communication support needs?

○ Yes ○ No

If yes, please give more information

Who does CYP live with?

Is the referred CYP an ex-member of British armed forces or dependent on such a person?

- ○ No
- ○ Don't know
- ○ Yes, ex-services member
- ○ Yes, dependant of an ex-services member

Ethnicity Code

- ○ (A) White British
- ○ (B) White Irish
- ○ (C) Other White background
- ○ (D) White and Black Caribbean
- ○ (E) White and Black African
- ○ (F) White and Asian
- ○ (G) Other mixed background
- ○ (H) Indian
- ○ (J) Pakistani
- ○ (K) Bangladeshi
- ○ (L) Other Asian background
- ○ (M) Caribbean
- ○ (N) African
- ○ (P) Other Black background
- ○ (R) Chinese
- ○ (S) Any other ethnicity group

Patients 18 and over

Employment status

Marital status

Current accommodation (Living alone/ with friends or family etc)

Family Members (relevant to referral)

First name	Surname	Relationship	Living at above address	DOB	Gender

Who has Parental Responsibility?

Please tick those that apply:

Child in Need

- ○ Yes
- ○ No
- ○ Historic

Child Protection Plan

- ○ Yes
- ○ No
- ○ Historic

Looked After Child

○ Yes ○ No ○ Historic

Special Guardianship Order

○ Yes ○ No ○ Historic

Residence Order

○ Yes ○ No ○ Historic

Adopted

○ Yes ○ No ○ Historic

Youth Offending Order

○ Yes ○ No ○ Historic

Previous CAMHS Involvement

○ Yes ○ No ○ Historic

Primary Reason for referral (mandatory NHSEi Information)

Please select only one main reason

○ First Episode Psychosis	○ Adjustment to health issues	○ Anxiety
○ Attachment Difficulties	○ Bi polar disorder	○ Conduct disorder
○ Depression/ low mood	○ Drug and Alcohol	○ Eating disorders
○ Family relationship difficulties	○ Gender discomfort	○ In crisis
○ Neurodevelopmental conditions	○ Obsessive compulsive disorder	○ Ongoing or Recurrent Psychosis
○ Organic Brain disorder	○ Perinatal mental health issues	○ Personality disorders
○ Phobias	○ Post-traumatic stress disorder	○ Self-care issues
○ Self-Harm behaviours	○ Unexplained physical symptoms	

Pre-referral discussion

Has there been a Pre-referral Discussion?

○ Yes ○ No

If yes, who was the discussion with?

Date of discussion

If “Yes”, and a referral has been agreed to, what was the agreed plan, and which CAMHS team, and which CAMHS practitioner will be allocated?

If Section 3 has been completed move to Section 5

Referral Information

What are you thinking CAMHS can do that would be helpful?

Please describe the current emotional/behavioural difficulties, how severe they are, what impact they have on functioning (school, home life, etc.), how long they have been present, and any issues about risk to self or others

What has been done already to try and help, what other services have the family worked with and what was the outcome? If there were previous referrals to CAMHS, what happened?

Professional Network

GP Details

GP Name

GP Practice Name

GP Address

GP Telephone

Permission to Contact?

○ Yes ○ No ○ Don't know

School Details

School

Name of School Contact

School Address

School Telephone

Permission to Contact?

○ Yes ○ No ○ Don't know

Referrer Details (only if the referrer is not the patient’s GP)

Referrer Name

Referrer Job Title

Referrer Address

Referrer Email

Referrer Telephone

Permission to Contact?

○ Yes ○ No ○ Don't know

Other Services/ Professionals Involved - 0

Name	
Service	
Address	
Contact no	

Permission to contact?

○ Yes ○ No

Office use only

Clinician	
Appointment date	
Codes: Referral problem	
Referral reason	
Client No	
CAMHS's action	

Once completed send to:

Email: tpn-tr.CYAF-Intake@nhs.net
Post: Camden Joint Intake –referrals, 120 Belsize Lane, London NW3 5BA