Child & Adolescent Mental Health Service
CAMHS ACCESS REFERRAL FORM

Please use this form for all Barnet, Enfield and Haringey CAMHS Services.
Please complete and return to the relevant service:

Barnet: CAMHS Referrals Administrator, Children's Services, Edgware Community Hospital, Burnt Oak Broadway, Middlesex, HA8 OAD or fax to 020 8732 6686
E-mail address: beh-tr.Barnetcamhsreferrals@nhs.net

Enfield: Enfield CAMHS, Charles Babbage House, 1 Orton Grove, EN1 4TU
Tel: 020 8379 1520 Fax: 020 8442 7284
E-mail address: beh-tr.enfieldcamhs@nhs.net

Haringey: Child & Adolescent Mental Health Service, Burgoyne Road Clinic, 58A Burgoyne Road, Haringey, London N4 1 AE or Fax: 020 8342 5934 Tel: 020 8342 5927

Referrer Information

Name of Referrer: Position: Address: Postcode	Tel No : Fax No:

Client Information

Name Of Referred Child/Young Person	Date Of Birth	Male / Female
Current Address Postcode	Home Telephone	Client's Mobile No
	Ethnicity	Main Language Spoken
	NHS Number	Interpreter Needed YES ☐ NO ☐

Has the child/young person agreed to this referral (if appropriate)? YES ☐ NO ☐	Is he/she able to travel to appointments? YES ☐ NO ☐	Is s/he on the Child Protection Plan? YES ☐ NO ☐
Name and address of GP	Name and address of school/college	

Parent /Guardian/Carer Information

Who does the young person live with? NAME RELATIONSHIP		Did they agree to this referral? YES ☐ NO ☐	Accommodated by the local authority YES ☐ NO ☐
Mobile number	Ethnicity	Main language spoken?	Interpreter required? YES ☐ NO ☐
Who should correspondence be addressed to? (i.e. carer and child, mother and child, father and child, parents and child, other):			
Name of person(s) with parental responsibility (if different from above) NAME RELATIONSHIP			Are they aware of the referral? YES ☐ NO ☐
Address (if different to above)			

Other members of the household (please list) NAME RELATIONSHIP	Significant others if not in household (please list) NAME RELATIONSHIP

Parental Permission

I/We are in agreement with this referral to CAMHS; and I/We give consent for my/our child to be seen individually if considered necessary.	Signed
	Print Name(s)

Referral information

Reason for referral ***(presenting problem, duration, severity including the nature of mental health concern)***
Background information ***(e.g. significant family difficulties, bereavement, illness parental separation, change and home or school):***

What is the referrer hoping to achieve by making this referral?
Please give relevant medical history/current medication.

Legal Status of Young Person *(please complete / tick as appropriate)*

Name of Social Worker Address	Telephone number Fax number
Are there any pending Court Proceedings? • If YES please give details (e.g. Youth Offending, Care Proceedings etc.)	YES ☐ NO ☐ Dates of any fixed hearings
If the person is "looked after" by the Local Authority, is there a care plan? • If YES does the care plan propose a referral for a mental health assessment?	YES ☐ NO ☐ YES ☐ NO ☐

Is the young person on the Child Protection Register? • If YES under what category of registration?	YES ☐ NO ☐ YES ☐ NO ☐
Nationality of young person	Immigration Status of young person

Other Professionals Involved

Are there other Professionals involved with the young person?		YES ☐ NO ☐
Professional	Name	Contact Details

Risk Assessment Form *(please complete for all referrals)*

Factors	Present?	If yes, please describe
Violence to others	YES ☐ NO ☐	
Cruelty to animals	YES ☐ NO ☐	
Use / collection / carrying of weapons	YES ☐ NO ☐	
Self-Neglect	YES ☐ NO ☐	
Deliberate Self Harm	YES ☐ NO ☐	
Deliberate Fire Setting	YES ☐ NO ☐	
Substance Use / Misuse	YES ☐ NO ☐	
Poor supervision at home	YES ☐ NO ☐	
Exploitation or abuse?	YES ☐ NO ☐	Physical ☐ emotional ☐ sexual ☐
Inappropriate behaviour (e.g. sexual)	YES ☐ NO ☐	
Psychotic symptoms (e.g. hearing voices)	YES ☐ NO ☐	
Interfamilial discord	YES ☐ NO ☐	
Family history of mental problems	YES ☐ NO ☐	
Family history of self-harm	YES ☐ NO ☐	
Family history of substance misuse	YES ☐ NO ☐	
Witness to violence	YES ☐ NO ☐	
Criminal activity	YES ☐ NO ☐	
School exclusion/ non-attendance	YES ☐ NO ☐	
Lack of social support (e.g. family or friends)	YES ☐ NO ☐	
Poverty / unemployment in family	YES ☐ NO ☐	

Educational Attainment Levels

SATS	
Reading Age	
Spelling Age	
Any Learning Difficulties concerns?	
Is the young person subject to Education, Health and Care (EHC) Plans?	YES ☐ NO ☐

Signed _____ **Date** _____

Print name _____

Copies of this form can be downloaded from the BEH-MHT website:
http://www.beh-mht.nhs.uk/gps-and-referrers/camhs-referrals.htm
(Click on CAMHS Access Referral Form)