**BLACK COUNTRY CAMHS SINGLE POINT OF ACCESS (SPA) REFERRAL FORM**

Please note that by referring to SPA you are referring to Specialist CAMHS and any agencies we are commissioned to work with. Information may be shared with all partnership organisations - young people will be referred or signposted as appropriate.

**ALL FIELDS ARE MANDATORY** unless otherwise specified and incomplete referral forms will be returned for your completion. Please complete this form electronically, if possible.

For more information on our services, please visit [www.BlackCountryMinds.com](http://www.BlackCountryMinds.com)

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| **Sandwell** | **Wolverhampton** | **Dudley** | **Walsall** |
| 48 Lodge Road,West Bromwich,B70 8NYTel: 0121 612 6620 Email: bchft.sandwellspa@nhs.net  | The Gem Centre, Neachells Lane,Wolverhampton,WV11 3PGTel: 01902 444 021 Email: BCHFT.WolvesCAMHSSPA@nhs.net | The Elms Health Centre, Slade Road, Halesowen,B63 2URTel: 01384 324 689Email: bchft.camhsdudley@nhs.net  | Canalside, Abbotts Street, Bloxwich, Walsall,WS3 3AZTel: 01922 607 400Email:bchft.walsallcamhs@nhs.net  |

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| **SECTION A – Child/Young Person’s Details** |
| Full Name: |  | Date of Birth: |  |
| Preferred Name/Alias: |  | Gender: | [ ]  Male [ ]  Female [ ]  Other, please state:  |
| Full Address and postcode: |  |
| Child/Young Person’s GP Details: |  |
| Ethnicity: |  | NHS Number: |  |
| Language: |  | Interpreter Required? | [ ]  Yes [ ]  No |
| Contact Number for Young Person: |  | Parent/Carer Name and Contact Number(s): |  |
| Parent/Carer e-mail address: |  | Are any family members Armed Forces veterans? | [ ]  Yes [ ]  NoIf yes, please give details: |
| School/College and academic year: |  | Mainstream School [ ] Specialist Provision [ ]  | Point of Contact in school: |  |
| Does the child/young person have a Learning Disability, Special Educational Needs or an Education Health Care Plan?  | [ ]  Yes [ ]  No If yes, please give details:  |
| Does the young person or family have any additional communication needs? (e.g hearing or visual impairment, use of Makaton or Sign Language? | [ ]  Yes [ ]  NoIf yes, please give details:  |

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| **SECTION B – Referrer’s Details** |
| Name: |  | Service/Department: |  |
| Full Address and Postcode: |  | Job Title/Profession: |  |
| Email Address: |  |
| Contact Number(s): |  |

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| **SECTION C – Consent, Needs and Professional Network**  |
| **Consent to referral**Is the child/young person aware of this CAMHS referral and is consent given? [ ]  Yes [ ]  No If no, details:Is the parent/carer aware of this CAMHS referral and is consent given? [ ]  Yes [ ]  No If no, details:Is there consent to share information with other professionals and services, including requesting school reports and forwarding the referral onto other services, if appropriate? [ ]  Yes [ ]  No If no, details:   **Needs**Does the child/young person have any existing physical/mental health conditions? [ ]  Yes [ ]  No If yes, details:Is the child/young person currently prescribed any medication? [ ]  Yes [ ]  No If yes, affix summary:Are there any barriers that may prevent attendance at initial appointment? [ ]  Yes [ ]  No If yes, details: |

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| **Legal Status**Tick any of the following that apply to the child/young person and complete details (see full referral criteria for further details):[ ]  Child or Young Person in Care\* [ ]  Subject to a Child Protection Plan\* [ ]  Subject to a Child in Need Plan\* [ ]  Adopted [ ]  Early Help Plan [ ]  Concerns around Exploitation Details:If a box above is ticked, please confirm that the Social Worker is aware of and supports the CAMHS referral? [ ]  Yes**Please note that additional information will be required from the social worker for a Child or Young Person in Care.** |
| Social Worker Details (\*must be completed if a box in the above section is ticked) |
| Name: |  |
| Address/Base: |   |
| Contact Number(s): |  |
| E-mail Address |  |

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| **Professional Network**Please tick and name other professionals currently involved with the child/young person (or family if relevant):[ ]  Paediatrician: [ ]  Educational Psychologist: [ ]  Social Worker:[ ]  School Nurse: [ ]  Occupational Therapist: [ ]  Speech & Language Therapist: [ ]  Health Visitor: [ ]  Dietitian: [ ]  Youth Justice Service: [ ]  Other: |

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| **SECTION D – Reason for Referral** |
| Please describe your reasons for referring the child/young person. Please refer to referral criteria for guidance.(additional information can be attached) |
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| Please outline any known risk issues (social, education or health) and state if these are current or historic. In the event of self-harm and/or suicidal thinking, please provide as much information as possible.In the event of any immediate safeguarding concerns, please ensure you have addressed these concerns and referred to MASH as appropriate. Information will be shared with the appropriate agencies regarding safeguarding concerns. |
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| **If referring for an eating disorder/eating concerns, please outline the results of initial tests** |
| **Weight** |  | **Height** |  |
| **Bloods**  | Please attach a copy of the young person’s most recent blood test results |

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| Do you consider this referral to be urgent? [ ]  Yes [ ]  No  |
| If yes, please give clear reasons on the basis of the child/young person’s mental health: |
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| Please list any supporting information that accompanies this referral form: |
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| Referrer’s Signature: |  | Date: |  |