



**East Midlands Forensic CAMHS Referral Form**

Please complete as fully as possible and send to [FCAMHSEastMidlands@nottshc.nhs.uk](mailto:FCAMHSEastMidlands@nottshc.nhs.uk)

**Date of referral** Click to select a date. **Date Received**  Click to select a date.

**Young Person’s Details**

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| --- | --- | --- | --- | --- | --- | --- |
| Name | | Preferred name | | Gender | | |
|  | |  | | M  F | | |
| Date of Birth | Age at referral | | NHS No. | | | Rio Number if known |
|  | Please select | |  | | |  |
| Nationality | | Religion | | | Ethnicity | |
|  | |  | | |  | |

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| --- | --- |
| Home address | Address at time of referral (if different) |
| Phone number: | Phone number: |
| Next of Kin/ Carer details | GP’s details |
| Name  Address  Phone number  Relationship to young person?  Aware of referral? Yes  No | Name  Address  Phone number  Aware of referral? Yes No |

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| Referrer’s details | Local CAMHS worker |
| Name:  Profession/designation:  Address:  Telephone Number:  Email address:  Sector Please select  If ‘other’ please specify | Name:  Profession/designation:  Address:  Telephone Number:  Email address: |

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| Other agencies involved at time of referral? | | | | | | | |
| CAMHS |  | Social Care |  | YOS | |  | |
| Education |  | Police |  | None | |  | |
| Other  Please specify | | | | | | | |
| Details of other professionals working with the young person | | | | | | | |
| Name:  Profession/designation:  Address:  Telephone Number:  Email address: | | | Name:  Profession/designation:  Address:  Telephone Number:  Email address: | | | | |
| Name:  Profession/designation:  Address:  Telephone Number:  Email address: | | | Name:  Profession/designation:  Address:  Telephone Number:  Email address: | | | | |
| Previous contact | | | | | Yes | | No |
| Has the young person had previous contact with CAMHS? | | | | |  | |  |
| Has the young person had previous contact Forensic CAMHS? | | | | |  | |  |

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| Living arrangements at time of referral | Social care status |
| Please select  If other, please specify | Please select  If other, please specify |
| Describe living conditions at time of referral: | |

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| **ACES** | Yes | No | Don’t know |
| Has the young person ever lived with a parent/ caregiver who went to jail/ prison? |  |  |  |
| Has the young person ever felt unsupported, unloved and/or unprotected? |  |  |  |
| Has the young person ever lived with a parent/ caregiver who had mental health issues? |  |  |  |
| Has a parent/ caregiver ever insulted, humiliated or put down the young person? |  |  |  |
| Has the young person’s biological parent or any caregiver ever had a problem with too much alcohol, street drugs or prescription medication use? |  |  |  |
| Has the young person ever lacked appropriate care by any caregiver? |  |  |  |
| Has the young person ever seen or heard a parent/ caregiver being screamed at, sworn at, insulted or humiliated by another adult? |  |  |  |
| Has the young person ever seen or heard a parent/ caregiver being slapped, kicked, punched, beaten up or hurt with a weapon? |  |  |  |
| Has any adult in young person’s household often or very often grabbed, slapped or thrown something at the young person? |  |  |  |
| Has any adult in the young person’s household ever hit the young person so hard that the young person had marks or was injured? |  |  |  |
| Has any adult in the household ever threatened the young person or acted in a way that made the young person afraid that they might be hurt? |  |  |  |
| Has the young person ever experienced any sexual abuse |  |  |  |
| Has there ever been significant changes in the relationship status of the young person’s caregivers? |  |  |  |
| Has the young person ever seen, heard, or been victim of violence in their neighbourhood, community or school? |  |  |  |
| Has the young person experienced discrimination? |  |  |  |
| Has the young person ever had problems with housing? |  |  |  |
| Has there ever been a time when the young person has been short of food? |  |  |  |
| Has the young person ever been separated from their parent or caregiver due to foster care or immigration? |  |  |  |
| Has the young person ever lived with a parent or caregiver who had a serious physical illness or disability? |  |  |  |
| Has the young person ever lived with a parent or care giver who died? |  |  |  |

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| Education status | | | Criminal justice status |
| Please select.  If other, please specify: | | | Please select.  If other, please specify: |
| Is there an EHCP | Yes | No |

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| Primary mental health diagnosis | Primary diagnosis (check one) | Comorbid Diagnosis  (check all relevant) | |
| ADHD |  |  | |
| Attachment disorder |  |  | |
| Anxiety |  |  | |
| Autistic Spectrum Disorder |  |  | |
| Conduct disorders (without clear borderline traits) |  |  | |
| Conduct disorder with clear borderline traits |  |  | |
| Depression |  |  | |
| Developmental Trauma |  |  | |
| Learning disability or significant difficulties |  |  | |
| Post-traumatic stress or allied disorder |  |  | |
| Psychosis |  |  | |
| Sensory processing disorder |  |  | |
| Other (specify): |  |  | |
| Emotional Dysregulation |  |  | |
| Selective mutism |  |  | |
| Developmental Language Disorder |  |  | |
| Acquired brain injury |  |  | |
| Anything not listed |  |  | |
| No diagnosis |  |  | |
| Diagnosis not possible/ available |  |  | |
| What medicine has been prescribed, if any? | | | |
| Who has prescribed the medicine, if known? | | | |
| Is the young person under the Mental Health Act? | | Yes | No |
| Is there any substance misuse?  If so, Please give details | | Yes | No |

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| Are there any other relevant queried diagnoses, signs or symptoms? |
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| Language and communication needs of the young person | Yes | No | Don’t know |
| Does the young person have difficulties listening to, remembering or understanding what you say? |  |  |  |
| Does the young person have difficulties finding the right words or give enough information when speaking? |  |  |  |
| Does the young person have difficulties interacting with others (poor social skills)? |  |  |  |
| Does the young person have a stammer or use unclear speech? |  |  |  |
| Does the young person have difficulties understanding written information including leaflets or letters? |  |  |  |
| Is there any other information regarding the young person’s communication that you would like to tell us about?  If so, Please give details | | | |

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| Occupational therapy | Yes | No | Don’t know |
| Are there any concerns that may require occupational therapy input – including but not limited to support with independent living, maintaining routine, concerns with sensory needs or difficulties with motivation? |  |  |  |
| If so, Please give details | | | |

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| Reason for referral |
| \* Please select a reason  If you have selected ‘multiple’ or ‘other’, please give details  Please tell us full details of specific incidents of concern, including dates: |

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|  | Yes | No |
| Is the young person aware of the referral to Forensic CAMHS? |  |  |
| Has the young person given consent for this referral?  If not, why? |  |  |
| Have you made all relevant professionals who work with the young person aware of this referral?  Please include any supporting information from them |  |  |

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| Referrer’s anticipated outcome  **\*\*This section must be completed before referral can be opened\*\*** |
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