**Referral Form to Access Tier 4 (including Inpatient) CAMHS Services for Children & Young People**

The NHSE CAMHS Specialised Mental Health Services Operating Handbook Protocol provides the guidance for Tier 4 services and the process for Secure CAMHS Referrals

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| **ALL FIELDS TO BE COMPLETED ELECTRONICALLY BY THE REFERRING CAMHS CLINICIAN. IF ANY INFOMRATION IS NOT AVAILABLE PLEASE STATE THIS IN THE RELEVANT BOX** |

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| **Referral Type:****(Delete as appropriate)** | Emergency / Urgent / Routine  |

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| **Please indicate which type of service may be required:** |
| Example: Home treatment/ General Adolescent/ PICU/ Low secure / Medium secure/ Eating Disorder/Learning Disability&ASC/ Deaf CAMHS / Not Known PLEASE BE CLEAR WITH SERVICE REQUESTED AND NOT ADD MULTIPLE SERVICES |

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| **Young Person’s Current Location:** |
| Home / Children’s Home/ Foster Care / CAMHS Inpatient Unit (specify type) / Paediatrics / A&E / Place of Safety 136 / Police Station / Secure Welfare Setting / Youth Custody / Foster care / Children’s Home / Other (specify type of placement) **(Delete as appropriate)**PLEASE ADD IF THE YOUNG PERSON IS CURRENTLY IN A&E OR PAEDIATRICS WITH CLOCK TICKING |
| **Address, Postcode & telephone number: (current location required)** |  |

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| **Please note the existing clinical team will retain responsibility for patient care until an admission into a CAMHS inpatient placement or alternative intensive support is provided** |

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| 1. **Young Person’s Personal Details**
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| **Full Name:** | **Previous Surnames:** |
| **AKA:**  |  |
| **Home Address:** | **Date of Birth:** |
| **NHS No.:** |
| **Gender:** |
| **Religion:** |
| **Ethnicity:** |
| **Postcode:** | **First Language:** |
| **GP Name, Address, Postcode** | **GP Contact Number:** |
| **Parent/Guardian Name:** | **Parent/Guardian Address:****PLEASE ADD ALL PERSONS WITH PARENTAL RESPONSIBILITY AND PARENTS/CARERS WITHOUT BUT WHO ARE INVOLVED** |
| **Disability, access, interpreter requirements –** **please provide details:**  |
| **Does the above person have Parental** **Responsibility?**  |
| **If no, is there a lead decision maker of those** **With parental responsibility?** **Name:**  |
| **Contact Telephone Number:** |
| 1. **Family and Social Situation**
 |
| **Composition of household and significant adults:** |  |
| **Social support network/ current significant relationships** |  |
| **If not living currently with family please give details of family members** |  |
| **Information about siblings (names, ages and relevant needs):** |  |

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| 1. **Young Person’s Education**
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| **Current School:** | **Previous School:** |
|  | **Current School Year:** |
| **Please detail school performance (academic, social, current bullying or any other issues):** |
| **Please detail any learning difficulties:** |
| **Does the child/young person have an Education Health Care Plan?**  |

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| 1. **Safeguarding**
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| **If there are current safeguarding concerns around this young person, please detail here:** Current concerns including sexual activity, exploitation and online issues |

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| 1. **Care Education & Treatment Review (CETR) – please include any previous CETR reports**
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| Please tick as appropriate:  | **Yes** | **No** |
| **Does the patient have a diagnosis of neurodevelopmental disorders, such as autism?**  |[ ] [ ]
| **Does the patient have a diagnosed learning disability?** |[ ] [ ]
| **Has a Community CETR been completed? (Please send CETR report with this form)** |[ ] [ ]
| **Does the CETR support referral to Tier 4?** |[ ] [ ]
| **Date of Community CETR:** | **PLEASE SEND CETR OUTCOMES IF POSSIBLE AT TIME OF REFERRAL OR SOON AFTER SO THESE CAN BE PART OF CARE PLANNING/REVIEWS** |
| **Please detail any relevant information regarding functional level, diagnosis, reasonable adjustments** **if known :** |  |
| 1. **Legal Status At Time of Referral**
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| **Mental Health Act: Please tick:**  |  **Yes** |  **No** |
| Is the young person subject to the Mental Health Act? | [ ]  | [ ]  |
| If Yes, which Section and date of detention: |
|  **S136 Please tick:** |  **Yes** |  **No** |
| Is the young person currently subject to S136?  | [ ]  | [ ]  |
| If Yes, time application was made:  |
| **Current status under Children’s Act Please tick:** | **Yes** | **No** |
| Voluntarily accommodated by the Local Authority (s20)  | [ ]  | [ ]  |
| Subject to Care Order (s31) | [ ]  | [ ]  |
| Subject to Secure Order (s25) | [ ]  | [ ]  |
| Child in Need Plan | [ ]  | [ ]  |
| Child Protection Plan | [ ]  | [ ]  |
| Any other legal status or issues ie police protection, guardianship - please specify |

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| 1. **Consent**
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|  Please tick as appropriate: |  **Yes** |  **No** |
| **Does the young person have competency/capacity to consent to this admission/intensive tier 4 interventions?****PLEASE BE CLEAR THAT THE YOUNG PERSON HAS AGREED TO THE ADMISSION AND IS FULLY AWARE OF THE PROCESS OF ADMISSION. REFER TO EPUT CAMHS ADMISSION PACKS FOR INFORMATION** | [ ]  | [ ]  |
| **Has the patient given consent for this referral?**  | [ ]  | [ ]  |
| **If No, under what legal framework is admission/intensive tier 4 interventions planned to take place?** |
| **Has the referrer obtained consent for information to be shared with the tier 4 service/admitting units and NHS England to ensure that appropriate services can be delivered?** | [ ]  | [ ]  |
| **Is there any restriction on sharing information?**  | [ ]  | [ ]  |
| **If Yes, please give details:** |

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| 1. **Reason for Referral for Access Assessment and Tier 4 Services**
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| **Rationale for referral:** Key information as to why an inpatient admission is necessary, what has been tried and why care and treatment cannot be effectively delivered in the community | WHY ARE YOU REQUESTING ADMISSION? PLEASE INCLUDE IMMEDIATE AND ONGOING CONCERNSIF ALREADY KNOWN TO SERVICES PLEASE ALSO INCLUDE WHO YOUNG PERSON HAS BEEN KNOWN TO, AND WHAT INTERVENTIONS HAVE PREVIOUSLY BEEN TRIED, ADDING WHY THESE MAY NOT BE WORKING OR SUPPORTING THE YOUNG PERSON TO REMAIN IN THE COMMUNITYIF KNOWN TO COMMUNITY SERVICES, PLEASE ALSO INCLUDE HISTORICAL AND CURRENT ENGAGEMENT WITH SERVICES, INCLUDING IF KNOWN WHY THE YOUNG PERSON HAS NOT ENGAGED WITH SERVICES. |
| **State current supports and alternatives to admission tried – please clarify why intensive input or admission is now needed** | Which services currently involved / Is there a crisis service available? Home treatment / intensive care service available? Other alternatives available? |
| **What planning is required to support this young person’s discharge from a Tier 4 service/inpatient setting? If 17.5 years or above, what is the transition to adult services plan?**  |  |
| 1. **Goals for the Admission / Tier 4 Intervention**
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| **From the referrer:** |
| **From the young person:** |
| **From the parent/carer:** |

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| 1. **Presenting Problem**
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| **Current Presentation:****PLEASE INCLUDE INFORMATION RELATING TO CIRCUMSTANCES LEADING TO ADMISSION. INCLUDE RISK INFORMATION RELATING TO RISK EG IF TAKEN AN OVERDOSE PLEASE INCLUDE HOW MANY TABLETS, WHAT TABLETS, ATTEMPTS TO CONCEAL OVERDOSE, DID THEY LEAVE NOTES OR MAKE CLEAR GOODBYES****IF EXPEREINCING HALLUCINATIONS/PSYCHOTIC SYMPOMS, PLEASE INCLUDE NATURE OF THESE: TIME, PATTERNS, RESPONSE TO THE EXPERIENCES,** **IF PRESENTATION OF MOOD DISORDER PLEASE INCLUDE LENGTH OF TIME, CHANGES IN MOOD/BEHAVIOURS, ANYTHING WHICH IS KNOWN TO IMPROVE MOOD OR ALTER MOOD PRESENTATION** |
| **History of presenting problem(s):** FOR example: precipitating factors, history of mental health difficulties. Please include duration, frequency and severity of triggers, Maintaining factors, Coping mechanisms, Current resources) If an Eating Disorder include weight/height, BMI, bloods results, recent ECG if available and current eating |
| **Current Mental State Examination:**PLEASE STATE TRIGGERS, PATTERNS, CHANGES IF KNOWN. INCLUDE:MOOD/BEHAVIOUR/ DEPENDENCE/INDEPENDENCE/ ACTIVITIES OF DAILY LIVING |
| **Current Diagnosis:**PLEASE INCLUDE ANY DIAGNOSIS IF KNOWN OR WORKING DIAGNOSIS. PLEASE INCLUDE ANY PATHWAYS WHICH YOUNG PERSON MAY HAVE BEEN WORKING WITH |
|  Please tick as appropriate: |  **Yes** |  **No** |
| **Has a comprehensive formulation been completed in the past 6 months?**  | [ ]  | [ ]  |
| **Please include any such comprehensive formulation** |
| **Describe any adverse childhood experiences (child abuse, family history of any significant mental or physical health difficulties, bullying, domestic abuse or other adverse experiences) :**  |  |
| **Previous Psychiatric History:**PLEASE INCLUDE INFORMATION ON PREVIOUS MEDICATIONS IF KNOWN. INCLUDING DATES WHEN ON MEDICATION |
| **Details of any previous admissions/Tier 4 input:** **Dates, type of unit, progress made as in-patient /with intensive help** | **PLEASE INCLUDE DATES AND HOSPITALS. FORWARD ANY PREVIOUS DISCHARGE SUMMARIES. IF NOT AVAILABLE, PLEASE SUMMARISE ANY OUTCOMES/PATHAYS FROM PREVIOUS ADMISSIONS** |

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| 1. **Physical Health**
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| **Details of any physical health conditions, disabilities and known allergies:** PLEASE INDICATE IF ANY PHYSICAL HEALTH INTERVENTIONS/INVESTIGATIONS HAVE ALREADY BEEN COMPLETED  |
|  Please tick as appropriate: |  **Yes** |  **No** |
| **Does this young person have any sensory impairment?** (e.g. visual disability, deaf, user of British Sign Language (BSL) or person with a hearing impairment) | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Does this young person smoke?**  | [ ]  | [ ]  |
| **If yes, please give details**: (include amount; frequency; motivation to use/change; effects) |

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| 1. **Risk / Protective Factors and Strengths**
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| **Date of recent risk assessment:** | **Completed By:** |
| **Details of Risk Assessment:** (attach copy if available)**PLEASE INDICATE FURTHER INFORMATION IN THE ADDITIONAL TEXT BOX IF YOU TICK YES TO ANY RISKS. PLEASE INCLUDE DATES WHERE APPROPRIATE IN THE FREE TEXT BOX.****PLEASE INCLUDE CURRENT AND HISTORIC RISKS- ALL ARE RELEVANT** |
|  Please tick as appropriate: |  **Yes** |  **No** |
| **Risk to self?** (including history of self-harm/suicidal ideation) | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Risk of absconding?** | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Risk to others? Include fire setting, violence damage to property, weapon use**  | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Self-neglect?** | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Risk from others which were not covered in safeguarding section? e.g. gangs, exploitation** | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Risky behaviour associated with Internet & Social Media use?** | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Any concerns about Substance Use?**  | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Any other Risk issues?**  | [ ]  | [ ]  |
| **If Yes, please give details:** |
| **Strengths of Individual:** |
| **Strengths of Family:** |
| 1. **Forensic History**
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| **Forensic history:** (include involvement with Youth Offending Team) |  |
| **Criminal charges:** |  |
| **Court orders:** |  |
| **Pending Court dates:** |  |
| **MAPPA status/category:** |  |

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| 1. **Details of Important Contacts**
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| **PLEASE COMPLETE TO ENSURE THAT THE APPROPRIATE PEOPLE ARE INFORMED OF THIS YOUNG PERSON’S CASE AND INVITED TO MEETINGS SUCH AS CPAs.** |
| **Care coordinator** | **Preferred school/college contact:** |
| **Name:** **Job Title:****Organisation:** **Telephone Number:****Email Address:** **Address:** | **Name:** **Job Title:** **Name of School/College :** **Telephone Number:****Email Address:** **Address:** |
| **Nearest relative (if under the MHA)**  | **Responsible CAMHS consultant**  |
| **Name:** **Job Title:****Organisation:** **Telephone Number:****Email Address:** **Address:**  | **Name:** **Job Title:****Organisation:** **Telephone Number:****Email Address:** **Address:** |
| **Social Worker**  | **Other (Please specify)** |
| **Name:** **Job Title:****Organisation:** **Telephone Number:****Email Address:** **Address:** | **Name:** **Job Title:****Organisation:** **Telephone Number:****Email Address:** **Address:** |

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| 1. **Details of Referring Clinician**
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| **Full Name and Profession: (Please print)** | **Address:** |
| **Date and time:** | **Job Title:**  |
| **Email:** | **Telephone no:** **Mobile no:** |
| **Name and contact details of Psychiatrist supporting this referral:** |  |

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| 1. **Name of CAMHS Case Manager (NHS England / New Care Model) clinical lead/ Commissioners**
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| **Name:** | **Region:** |
| **Email:** | **Tel:** |
| **Responsible CCG :- if in a residential or out of area placement, please include details of the originating CCG responsible for the placement**  |  |
| **Responsible Local Authority:- if in a residential or out of area placement, please include details of the originating LA responsible for the placement** |  |

**Important Note**

Please ensure that the CAMHS Case Manager / New Care Models Manager receive a copy of this Referral Form at the same time as the in-patient service to whom you are referring, for all referrals. NHS England seeks to ensure young people are placed in the closest bed to home which will meet their needs. Patients who may need out of area placements will need to be discussed and approved by the CAMHS Case Manager (NHS E or NCM) in hours, to assure that all services closest to home have been approached and reduce any potential delays in admission. If a CAMHS Case Manager (NHS E or NCM) is not available eg: out of hours, the referrer should follow normal process as per operating handbook. NHS England will support an admission to an Out of Area Service as long as there is evidence that all options closer to home have been exhausted and it is in line with the access assessment. **Lack of or out of date information and incomplete sections can result in a delay in admission due to the inpatient unit not having the necessary and relevant information to make clinical decision.**

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| 1. **ASSESSMENT FOR ACCESS TO TIER 4 SERVICES: Endorsement for Tier 4 Services**

**To be completed by Tier 4 Authorising Clinician**  |
| **Date & time access assessment completed:**  |  |
| **Desktop review of referral/telephone discussion with referring clinician:** |  |
| **Type of Service agreed: inpatient unit type & level of security OR other type of Tier 4 input (Alternatives to Admission)**  |  |
| **If not offering services, please give reasons why; please give recommendations of what should be considered.** |  |
| **Name and designation of Tier 4 Authorising Clinician completing this section:** |  |
| **Name of Case Manager [NHS England/New Care Model/Commissioner] discussed with if Out of Area Service required.**  |  |

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| 1. **Outcome of the Referral (To be completed by the Tier 4 Service Accepting the Young Person )**
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| **Recommendation** | Admission / Alternative to Admission **(Delete as appropriate)** |
| **Name of Unit / Service**  |  |
| **If not offering services, please give reasons why; please give recommendations of what should be considered.** |  |
| **Goals for admission / intensive service input:** |  |
| **Requirements and anticipated plan for discharge: (e.g. Identified GAU bed for PICU admission, Placement needs after this intervention or similar)** |  |
| **Name & designation of Clinician completing this section:** |  |
| **Date:** |  |