

**HUB Tel:** 0300 123 0907 (option 4)  
**Fax:** 01782 828587  
 Email: [sch-tr.camhspla@nhs.net](mailto:sch-tr.camhspla@nhs.net)

**CAMHS MULTI-AGENCY REFERRAL FORM**

(Community CAMHS, Community CAMHS Eating Disorder, CAMHS Disability, CAMHS ASD,  
 Yellowhouse,

Paediatric Psychology and Tier 2 CAMHS services)

**PLEASE COMPLETE ALL BOXES TO ENSURE THE REFERRAL IS PROCESSED**

**Referrer details**

<b>Date of Referral:</b>	<b>Name:</b>	<b>Job title:</b>
<b>Address:</b>		<b>Telephone numbers:</b>
<b>Postcode:</b>		
<p>For all urgent referrals, please contact the Hub on Tel: 0300 123 0907, Option 4.</p> <p>Please confirm you have the agreement of the young person/their carer to make this referral: <input type="checkbox"/></p> <p>Please return via post or email to <a href="mailto:sch-tr.camhspla@nhs.net">sch-tr.camhspla@nhs.net</a></p>		
<p>Please describe what services you have already provided to the child family:</p>		

**Child/Young Person referral details**

<b>Name:</b>	<b>D.O.B:</b>	<b>Ethnicity:</b>	<b>Gender:</b>	<b>NHS number:</b>
<b>Address:</b>		<b>Telephone:</b>		
<b>Postcode:</b>		<b>Mobile:</b>		
<b>How long have they lived at this address?</b>		<b>Preferred contact:</b>		

Name of school/college/nursery		Details of any educational healthcare plan:		
Status/legal status (eg Looked After Child, Early Help, CIN, Care Order) – please attach copy of plan if child protection:				
<b>Parental details</b>				
Name of Parent/Carer:		Contact number(s):		Ethnicity:
Name of Parent/Carer:		Contact number(s):		Ethnicity:
Who has parental responsibility?		Who does the child live with?		
Address: ( for both parents if different from young person):				
Any additional needs of parent (e.g. disability/literacy/interpreter etc)				
Any additional needs of child (e.g. disability/literacy/interpreter etc)				
Other children:		D.O.B	Ethnicity	Gender:
<b>GP Details</b>				
Name:		Address:		Telephone:

**For referrals where there is a suspected eating disorder – please provide the additional information:**

**Weight history (weight change / duration of weight change, current weight and height)**

**Compensatory behaviours and duration use of laxatives – yes / no / frequency**

**HUB Tel:** 0300 123 0907 (option 4)  
**Fax:** 01782 828587

Email: [sch-tr.camhspla@nhs.net](mailto:sch-tr.camhspla@nhs.net)

**Self-induced vomiting – frequency**

**Exercise – frequency / intensity**

**Amenorrhoea -**

**Any other information – including results from blood tests/ investigations. Previous inpatient admissions. ECG as required**

**Current dietary intake**

**Physical reports – BP/pulse**

### Details of the Presenting Problem

Please give details about behaviours observed/ mood/ emotions/communication/appetite/sleep:

How long has this difficulty been present?

Is this difficulty present in all areas? E.g. at home, at school, socially?

Social History (Please include details of any relevant family circumstances, life events, bereavements, parental mental health / Learning Disability / Ill Health / Substance Misuse / Domestic Abuse)

Does the young person have a learning disability? Please give details on level of severity:

Details of any current medication/dosage:

Any known risk factors – child and family? (for e.g. violence, substance misuse)

Additional relevant information:

**HUB Tel:** 0300 123 0907 (option 4)  
**Fax:** 01782 828587

Email: sch-tr.camhs.hc@nhs.uk

**AGENCIES WHICH HAVE SUPPORTED THE FAMILY**

<b>Agency</b>	<b>Past Involvement</b> (with approximate dates)	<b>Current Involvement</b>	<b>Contact Person and Telephone Number</b>
<b>Social Care</b>			
<b>Paediatrician</b>			
<b>Education (School nurse)</b>			
<b>Triple P</b>			
<b>Health Visitor</b>			
<b>Youth Offending Service</b>			
<b>Other</b>			

**Is this a referral for a Looked After Child? – please ensure SDQ and consent form are attached**

**If the referral is for a Looked After Child, is the child from Stoke, Staffordshire or out of area? Please state:**

**Is this referral for an ASD assessment? – please give details on the child’s communication, social interaction and rigid, repetitive and stereotyped behaviours (attach separate letter)**

**The information from this form will be discussed within a multi-agency professional team to assess the appropriate course of action. We will contact you in writing to advise you of the outcome. You may be contacted for more information if required. This information will be recorded on North Staffordshire Combined Healthcare’s database**

**CONSENT OF CLIENT**

**I have discussed CAMHS services with the young person/family and they agree to this referral.**

<b>Signature of referrer:</b>	<b>Date:</b>
-------------------------------	--------------

**I consent to the above referral and any assessment that may be required. I consent to information being collated and passed to the appropriate agencies.**

<b>Signature of Parent/ Carer/ Young person:</b>	<b>Date:</b>
--	--------------

- Do you consent to receiving messages from us via text? **Yes**  **No**   
 Do you consent to us leaving voicemail on landline? **Yes**  **No**   
 Do you consent to us leaving voicemail on mobile: **Yes**  **No**