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| **CAMHS** **Single Point of Access (SPA)****Referral Form (For Professionals only)**

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| **Date of Referral:** |

**Please fill in as much detail and ALL sections with an \* to avoid delay in processing this referral.** |  Milton Keynes Specialist Child and Adolescent Mental Health (MKSpCAMHS) Eaglestone Health CentreHospital Campus, Standing WayMilton Keynes, MK6 5AZTel: 01908 724228Email: **cnw-tr.mkspcamhsspa@nhs.net** |

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| **\*Section 1: Child / Young Person and Family name, address and contact details:** |
| **Title:** | Mr / Mrs/ Ms | **Date of Birth:** |  |
| **Forename:** |  | **Surname:** |  |
| **Also known as:** |  | **Ethnicity:** |  |
| **NHS No (if known)** |  | **Age:** |  |
| **Address (Current)** |  |
|  | **Post Code:** |  |
| **Landline / Home Telephone number:** |  | **Child / Young Persons Mobile Number:** |  |
| **Email address (MANDATORY):** |  | **School (MANDATORY):** |  |
| **Language or communication needs:** |  | **Translator / Interpreter required?****(Inc. Sign language?)** | Yes | No | **If yes, which language / dialect/ sign language:** |
| **Armed Forces Status:** | Ex-services member |  | **Is this person a carer/young carer** | **Yes** | **No** |
| Not an ex-services member or their dependent  |  | ***Additional Information:*** |
| Dependent of an ex-services member |  |
| Unknown (Asked and does no know.is not sure) |  |
| Not stated (Asked but declined to provide a response) |  |

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| **\*Section 2: Reason for Referral / Current Mental Health Concerns****If Eating Disorder is of concern height and weight must be included, without this information referral will be refused**  |
| *Brief detail of presenting problem (please consider the following);**Presenting concern, family life/ circumstances, daily functioning, appetite, sleep, self-harm, suicidal ideations any safeguarding Issues, Social Services involvement, any intervention that have been tried, any school/college attendance issues**Please continue on a separate sheet if needed.*  |
| **\*Section 3: Referrers name, address and contact details:** |

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| **Name**  |  |
| **Job Title / Profession:** |  |
| **Address:** |  |
|  | **Post Code:** |  |
| **Contact Details:** | **Tel no.** | **Mobile:** | **Email:** |

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| **\*Section 4: Consent and Confidentiality of the Person referred:** |
| **Has the person given consent to the Referral? Yes No** **If the individual is under 16 has the person with parental responsibility been informed and given consent to the referral? Yes No****Name of person who holds Parental Responsibility:** **Relationship to young person:****Address of person with Parental Responsibility:****Telephone contact no.( if different from above):** |
| **Section 5: Is there any history of parental mental health difficulties or substance misuse?** |

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|  | Yes |  | No Unknown If Yes please state difficulty or difficulties;  |

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| **\*Section 6: Current General Practitioner name and address:** *(if not referrer)* |
| **Name of Doctor:** |  |
| **Surgery Name:** |  |
| **Surgery Address:** |  |
|  | **Post Code:** |  |
| **Telephone Number:** |  |

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| **Section 7: Does the Child / Young Person have a Social Worker?**  |

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|  | No |  | Yes If Yes is the child or young person a Looked After Child? Yes No  |

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| **Name of Allocated Social Worker** |  |
| **Telephone or Contact Details** |  |
| **Section 8: Current Education name and address:** *(we will not contact school unless parent/patient consent has been given)* |
| **Name of School/College** |  |
| **Address:** |  |
|  | **Post Code:** |  |
| **Telephone Number:** |  |

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| **Section 9: Background History** |
| **Is there any other diagnosis: (physical health, neurodevelopmental, learning disability)** |

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| **\*Section 10: Risk Assessment** |
| History of Risk Yes/No | If Yes please state risk; |
| Current Risk Yes/No | If Yes, what is the current risk? |
| Level of Risk |  Is the risk Slight, Moderate, Severe, Very Severe, Not Known? (Please choose the most appropriate option) |
| Is there drug and alcohol misuse? Yes / No | If yes which substance/s is being misused? |
| Have they been referred to drug and alcohol services?Yes/No | If Yes which services have been involved and when was the Referral done? |
| Is there an agreed safety plan? Yes/No | If Yes please give details; |

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| **Section 11: Any other information that may be useful:**  |
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Please email completed referral to: cnw-tr.mkspcamhsspa@nhs.net If a copy cannot be emailed please post to the MKspCamhs (F.A.O. SPA) address as stated above.