Please complete electronically and return form to:

ntawnt.fcamhs@nhs.net

C/o The Kolvin Service C/o Adolescent Forensic Outpatient Service

(Community Adolescent Forensic Service) Acklam Road Hospital

Ground Floor, St Nicholas House Middlesbrough

St Nicholas Hospital Jubilee Road TS5 4EE

Newcastle upon Tyne Direct Dial: 01642 529 650

NE3 3XT

Direct Dial: 0191 245 6629

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| **Forensic Child and Adolescent Mental Health Service****(North East and North Cumbria)**  **Referral Form**  |

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| * **Please ensure you have read the Referral Leaflet, believe the young person to meet the referral criteria and you have the current version of the referral form. (Leaflet and form available at:** [www.cntw.nhs.uk/fcamhs](http://www.cntw.nhs.uk/fcamhs)**)**
* Please complete all sections giving as much detailed information as possible.
* The referral form may be returned to you if it is not fully completed, which may result in a delay in the young person being accepted into the service.
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| **SECTION A: Consent** |
| Date of Referral | Click here to enter a date. |
| * The young person should be informed that they are being referred to FCAMHS.
* The only exception to this will be if the referring professional believes informing the young person will increase risks to the young person and/or others.
 |
| Have you discussed the referral with the young person? | Choose an item. |
| Has the young person agreed/consented to the referral? | Choose an item. |
| If **NO** to either of the above, please explain the reason: | Click here to enter text. |
| Has consent been obtained from parent/carer/person with parental responsibility? | Choose an item. |
| If **NO**, please specify the reasons: | Click here to enter text. |
| The referrer must decide if there are sufficient grounds for safeguarding reasons to submit a referral without the required consent. **Without the young person’s consent, FCAMHS will be unable to provide direct assessment/intervention even if it is indicated.** |
| * **By submitting this referral, you confirm that you have followed your local consent policies. This includes gaining the relevant consent for referring to FCAMHS, and the sharing of appropriate information across agencies involved.**
* **FCAMHS (North East and North Cumbria) is a service provided by CNTW and TEWV and therefore relevant information may be shared between the two organisations.**
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| **SECTION B: Young Person’s Information** |
| **If the young person is known to CNTW or TEWV please complete Paris or RIO ID.**  |
| **Paris ID:** | Click here to enter text. | **RiO ID:** | Click here to enter text. |
| **Forename** | Click here to enter text. | **Surname** | Click here to enter text. |
| **Preferred name/ also known as** | Click here to enter text. | **Date of birth** | Click here to enter a date. | **Age at referral** | Choose an item. |
| **Sex assigned at birth** | Choose an item. | **Identified gender** | Click here to enter text. | **Ethnicity** | Choose an item. | **Religion** | Click here to enter text. |
| **NHS Number** | Click here to enter text. | First language | Click here to enter text. |
| **Home address** Postcode | Click here to enter text. | Address at time of referral (if different) Postcode | Click here to enter text. |
| **Tel No(s)** | Click here to enter text. | **Tel No(s)** | Click here to enter text. |
| **Parent/carer/person with parental responsibility** | **Current General Practitioner** |
| **Name** | Click here to enter text. | **Name** | Click here to enter text. |
| **Address** Postcode | Click here to enter text. | **Address** Postcode | Click here to enter text. |
| **Tel No(s)** | Click here to enter text. | **Tel No(s)** | Click here to enter text. |
| **Email address** | Click here to enter text. | **Email address** | Click here to enter text. |

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| **SECTION C: Referrer Information** |
| * The referrer must be a care coordinator/lead professional who will retain overall responsibility for the case and remain involved until the conclusion of any FCAMHS (North East and North Cumbria) involvement.
* As referrer you agree to take full responsibility for ensuring all relevant professionals’ details and information are provided to FCAMHS.
 |
| Name | Click here to enter text. | Tel No(s) | Click here to enter text. |
| Title/designation | Click here to enter text. | Address Postcode | Click here to enter text. |
| Service | Click here to enter text. |
| Email address | Click here to enter text. |
| How long has the young person been open to you: | Click here to enter text. |
| * **Please ensure you have discussed this referral and submission with your manager/supervisor.**
* **Please enter the details of this individual below.**
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| Manager’s Name  | Click here to enter text. | Tel No(s) | Click here to enter text. |
| Title/designation | Click here to enter text. | Email address | Click here to enter text. |

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| **SECTION D: Agencies Involved** |
| **CAMHS/CYPS contact (not FCAMHS)** |
| If this referral is being made by CNTW CYPS/TEWV CAMHS, please ensure that the CPA reflects enhanced care coordination and care plans/risk assessments are up-to-date.  |
| Current CAMHS/CYP Service | Choose an item. | Previous CAMHS/CYP Service(s) | Choose an item. |
| Date current CAMHS/CYPS episode started | Click here to enter text. | Dates of previous CAMHS/CYP Service(s) and professional(s) involved | Click here to enter text. |
| If yes, is young person on Enhanced CPA | Choose an item. | Current diagnosis: | Click here to enter text. |

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| **CAMHS professionals involved** |
| Name | Click here to enter text. | Name | Click here to enter text. |
| Title/designation | Click here to enter text. | Title/designation | Click here to enter text. |
| Service | Click here to enter text. | Service | Click here to enter text. |
| Email address | Click here to enter text. | Email address | Click here to enter text. |
| Tel No(s) | Click here to enter text. | Tel No(s) | Click here to enter text. |
| Address Postcode | Click here to enter text. | Address Postcode | Click here to enter text. |
| Has referral been discussed? | Choose an item. | Has referral been discussed? | Choose an item. |

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| **Current Living Arrangements** |
| Birth family |[ ]  Foster Care |[ ]  Adoptive Family |[ ]
| Residential Care |[ ]  Supported Accommodation |[ ]  Independent Living |[ ]
| Secure Care Setting (please specify): | Click here to enter text. |
| Mental Health Setting (please specify): | Click here to enter text. |
| **Social Care Status** |
| LAC: | S20 |[ ]  S31 |[ ]  Leaving Care |[ ]  Subject to CP Plan |[ ]
| Child In Need |[ ]  Secure Care Order |[ ]  None |[ ]   |
| Other (please specify): | Click here to enter text. |
| **Social Care professionals involved** |

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| --- | --- | --- | --- |
| Name | Click here to enter text. | Name | Click here to enter text. |
| Title/designation | Click here to enter text. | Title/designation | Click here to enter text. |
| Service | Click here to enter text. | Service | Click here to enter text. |
| Email address | Click here to enter text. | Email address | Click here to enter text. |
| Tel No(s) | Click here to enter text. | Tel No(s) | Click here to enter text. |
| Address Postcode | Click here to enter text. | Address Postcode | Click here to enter text. |
| Has referral been discussed? | Choose an item. | Has referral been discussed? | Choose an item. |

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| **Education Status** |
| Name of School/College | Click here to enter text. | Mainstream |[ ]
| Contact Name | Click here to enter text. | Mainstream SEN Unit |[ ]
| AddressPostcode | Click here to enter text. | PRU |[ ]
|  |  | SEN School |[ ]
|  |  | Hospital School |[ ]
| Tel No(s) | Click here to enter text. | Home Tuition |[ ]
| Email address | Click here to enter text. | Employed |[ ]
| EHCP | Yes [ ]  No [ ]  | Vocational Training |[ ]
| If YES, please give date of last plan | Click here to enter a date. | NEET (Not in Education, Employment or Training) |[ ]
| Does the young person have any communication barriers | Yes [ ]  No [ ]  | Other | [ ]  |
| If YES, please give details: | Click here to enter text. |
| Educational Psychology report | Choose an item. | If YES, date report was completed | Click here to enter a date. |
| **Criminal Justice Status** |
| None |[ ]  Under investigation |[ ]  Recent Police contact (within the last 12 months) |[ ]
| Pre-court order |[ ]  On remand |[ ]  Sentenced to custodial order |[ ]
| Sentenced on community order |[ ]  Other | Click here to enter text. |
| Involved with YOT | Choose an item. |  |
| Current Police investigations, charges or convictions: | Previous Police investigations, charges or convictions: |
| Click here to enter text. | Click here to enter text. |

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| **Criminal Justice professionals involved (YOT, Probation, etc.)** |
| Name | Click here to enter text. | Name | Click here to enter text. |
| Title/designation | Click here to enter text. | Title/designation | Click here to enter text. |
| Service | Click here to enter text. | Service | Click here to enter text. |
| Email address | Click here to enter text. | Email address | Click here to enter text. |
| Tel No(s) | Click here to enter text. | Tel No(s) | Click here to enter text. |
| Address Postcode | Click here to enter text. | Address Postcode | Click here to enter text. |
| Has referral been discussed? | Choose an item. | Has referral been discussed? | Choose an item. |
| **Other professionals involved (Substance Misuse worker, CSE worker, support worker, CJLD, etc.)** |
| Name | Click here to enter text. | Name | Click here to enter text. |
| Title/designation | Click here to enter text. | Title/designation | Click here to enter text. |
| Service | Click here to enter text. | Service | Click here to enter text. |
| Email address | Click here to enter text. | Email address | Click here to enter text. |
| Tel No(s) | Click here to enter text. | Tel No(s) | Click here to enter text. |
| Address Postcode | Click here to enter text. | Address Postcode | Click here to enter text. |
| Has referral been discussed? | Choose an item. | Has referral been discussed? | Choose an item. |
| Name | Click here to enter text. | Name | Click here to enter text. |
| Title/designation | Click here to enter text. | Title/designation | Click here to enter text. |
| Service | Click here to enter text. | Service | Click here to enter text. |
| Email address | Click here to enter text. | Email address | Click here to enter text. |
| Tel No(s) | Click here to enter text. | Tel No(s) | Click here to enter text. |
| Address Postcode | Click here to enter text. | Address Postcode | Click here to enter text. |
| Has referral been discussed? | Choose an item. | Has referral been discussed? | Choose an item. |

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| **SECTION E: Identified Risks** |
| Physical abuse |[ ]  Sexual abuse |[ ]  Self-harm |[ ]  Substance misuse |[ ]
| Emotional abuse |[ ]  Neglect |[ ]  Harm to others |[ ]  Offending Behaviour |[ ]
| Child Sexual Exploitation |[ ]  Child Criminal Exploitation |[ ]  Child County Lines Exploitation |[ ]  Terrorism/Extremism |[ ]
| Other |[ ]  Details of other: | Click here to enter text. |
| Has a risk assessment been completed? If so please attach  | Choose an item. |
| Please list completed risk assessment/s | Click here to enter text. | Date last updated and author: | Click here to enter text. |
| Has this young person been discussed within your internal service/agency risk management processes? | Choose an item. |

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| **SECTION F: Reasons for referral to a specialist forensic mental health service**  |
| *High risk of high harm to others behaviour:** Please provide details of high risk of high harm to others/forensic behaviours including specific incidents of concern.
* Include dates of incidents within the last 12 months.
* Please attach a separate chronology of incidents for behaviours prior to this.

Click here to enter text. |
| *Mental health or Neurodevelopmental diagnosis / disability* *and/or concerns:*Click here to enter text. |
| Please describe what is currently in place to the support young person including what has been implemented/tried and how the young person has responded: |
| Click here to enter text. |
| What is the young person’s understanding of their risks?  |
| Click here to enter text. |
| What are the parent/carer’s understanding of the risks? |
| Click here to enter text. |
| If a referral is accepted, FCAMHS will offer a multi-agency professionals consultation meeting. Please explain your anticipated outcome from this consultation and what support you feel FCAMHS will be able to provide: |
| Click here to enter text. |