

To make a referral email or send this form to:

**Kent Children and Young People’s Mental Health Service**

Address: 12 Foster Street, Maidstone, Kent ME15 6NH

Telephone: 03001234496

Email: [nem-tr.kentcypmhs**.**referrals@nhs.net](mailto:nem-tr.kentcypmhsreferrals@nhs.net)

**Kent Single Point of Access Referral for**

**Kent Children and Young People’s Mental Health Services**

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| **Section 1** | | **Name and Contact Details of Person Making Referral:** | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | Address: | | | |  | | | | | | | | | | | | |
| Job Title or Relationship  to child: | | | |  | | | | |
| Agency (if professional  making the referral): | | | |  | | | | |
| Telephone: | | | |  | | | | | Email: | | | |  | | | | | | | | | | | | |
| **Section 2** | | **Child / Young Person’s Details** | | | | | | | | | | | | | | | | | | | | | | | |
| Child’s Name:  (Surname) (First Name) | | | | | | | | | | M  F | | | | | | Date of Birth: | | | | | | | | | |
| Address:  Postcode: | | | | | | | | | | | | | | | | NHS Number: | | | | | | Social Services  identification number  (if known): | | | |
| Name of School / Nursery / College:  Address:  Telephone:  Contact Name: | | | | | | | | | |
| Home Telephone: | | | | | Parents Mobile: | | | | | | | | | | | First Language: | | | | | | | | | |
| Email Address: | | | | | Child’s Mobile: | | | | | | | | | | | Interpreter required:  Yes  No  Specify Which Language: | | | | | | | | | |
| Religion: | | | | | Nationality: | | | | | | | | | | | Ethnicity: | | | | | | | | | |
| Young Person’s Preferred Method of Contact: | | | | | | | | Letter: | | | | | | Phone: | | | | | Text: | | | | | Email: | |
| GP Name: | | | | | | | | | | | | | | | | | GP Telephone Number: | | | | | | | | |
| GP Surgery Address: | | | | | | | | | | | Subject to Child Protection Plan : Y  N  Are they a Child In Need: Y  N | | | | | | | | | | | | | | |
| Provide brief details of any current/previous safeguarding  concerns: | | | | | | | | | | | | | | |
| Is this a Looked After Child: Y  N  Name of Local Authority who is Responsible : | | | | | | | | | | | | | | |
| **Section 3** | | **Next of Kin and Parental Responsibility Details:** | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Person(s) with Parental Responsibility? | | | | | | | | | | | | | | | Interpreter required:  Yes  No  Specify Which Language: | | | | | | | | | | |
| Parent / Carer’s Name (if different from above): | | | | | | | | | | | | | | | Relationship to Young Person: | | | | | | | | | | |
| Address:  Postcode: | | | | | | | | | | | | | | | Telephone: | | | | | | | | | | |
| Mobile: | | | | | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 4** | | **Name of other Professionals / Agencies involved, if known:** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Social Care | | Currently  Previously | | |  | Nursery/Preschool | | | | | | | | | | | | |  | Educational Psychologist | | | | |
|  | Kent County Council Early Help Team | | | | |  | Educational Team (e.g. learning/behavioural support, etc.) | | | | | | | | | | | | |  | Educational Welfare Officer | | | | |
|  | Health Visitor | | | | |  | School Nurse | | | | | | | | | | | | |  | SENCo | | | | |
|  | Previously Known to CAMHS (e.g. PMHW; Counsellor) | | | | |  | Youth Offending Service | | | | | | | | | | | | |  | Children With Disabilities Team (Social Care) | | | | |
|  | 3rd Sector Organisation(s) | | | | |  | Child Development Team (Health) | | | | | | | | | | | | |  | Hospital/Community Doctor | | | | |
|  | Other (specify): | | | | | | | | | | | | | | | | | | | | | | | | |
| Please provide any relevant information regarding involvement of other professionals/agencies | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Section 5** | | **Reason for referral:**  Please state nature of difficulties, onset, frequency, duration, interventions tried, any relevant medical history. | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 6** | | **Impact on Child/ young person at school and social development:**  Please describe how this impacts on the child’s behaviour, social development, school/nursery/college performance/attainment, relationships, activities, wellbeing, and physical health/routines. | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 7** | | **Social/family background:**  Please provide details of family composition, ages, occupations/employment and parental mental and physical health concerns. Sibling group, Relevant or significant life events; e.g. Divorce/separation, bereavement, domestic violence, drug/alcohol misuse. | | | | | | | | | | | | | | | | | | | | | | | |
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| |  |  | | --- | --- | | **Section 8** | **Medication:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please give details of any known medications the Child/Young Person is currently taking. | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  | | --- | --- | | **Section 9** | **Outcomes:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child/Young Person:**  Please give details of what the child/Young Person would like to happen as a result of this referral. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent/Carer:**  Please give details of what the parent/carer would like to happen as a result of this referral. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referrer:**  In making this referral, what outcomes are you anticipating for the Child/Young Person/Family? | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 10** | | **Summary of risks:** | | | | | | | | | | | | | | | | | | | | | | | |
| **Child/ Young Person** | | | | | | | | | | | | **Current**  **(last 2 weeks)** | | | | | | **Recent Past (last 6 months)** | | | | | **Historical Past (over 6 months)** | | |
| Self-Harm | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| Harm to others | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| Suicidal thoughts/ intentions | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| Physical/sexual/ emotional abuse | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| Significant medical needs/ Disability | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| **Parent/ Environment** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parental mental illness | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| Domestic violence | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| Parenting difficulties | | | | | | | | | | | |  | | | | | |  | | | | |  | | |
| For Each Risk Identified, Please Provide Details: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 11** | | **Information Sharing And Consent:**  **Please note this section is important and should be completed** | | | | | | | | | | | | | | | | | | | | | | | |
| Referrals cannot be made without the agreement of the parent/carer and/or young person (subject to Gillick competence). Confidentiality is respected in accordance with the Data Protection Act. We also have a duty to refer any child who may be in need of protection to Social Services. I agree to information being shared and discussed between professionals and other agencies to help me/my child and family. I understand I will be consulted following these discussions regarding any future planning and actions. I understand I can withdraw my consent at any time to information being shared and  Verbal consent obtained from the young person (subject to Gillick competence)  **Yes  No**  Verbal consent obtained from parent/carer  **Yes  No**  **Comments (if any):**    **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | |