

To make a referral email or send this form to:

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

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

Telephone: 03001234496

Email: nem-tr.kentchildrenandyoungpeoplehealthservices@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 professionalmaking 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 Servicesidentification 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 [ ]  NoSpecify 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 [ ]  NoSpecify 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:** |

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| Please give details of any known medications the Child/Young Person is currently taking.      |
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| **Section 9** | **Outcomes:** |

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| **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:**       |