MAKING A REQUEST FOR INVOLVEMENT
A GUIDE FOR REFERRERS

This guidance is prepared to outline the process to follow to enable referrers to make a Request for Involvement (referral) for a child\young person up to 18th Birthday to:

- **Child and Adolescent Mental Health Service (CAMHS)**

This guide is <u>not</u> intended to replace any existing pathways.

We are

kind • a team • respectful • always learning

We are LSCft

REQUEST FOR INVOLVEMENT

Please complete a referral form if you wish to make a referral\request for a child\young person.

The referral form (see Appendix 5) has been designed to capture all necessary referral information to enable health professionals within the service to make an accurate decision regarding a child's needs to access service(s) and to enable a timely decision to be relayed to referrers and parents\carers.

MAKING A ROUTINE REQUEST\REFERRAL

To make a routine referral for a child\young person to access our services, please complete a referral form (see Appendix 5).

Please email or post the completed form (see email and address details below).

If you wish to receive the form by email, please contact our business support team (contact details are below):

Phone: 01229 402696

E-mail: **CAMHSSouth@lscft.nhs.uk**
or
NHS Net: camhssouth@nhs.net

Address: South Cumbria CAMHS
Alfred Barrow Health Centre
Barrow in Furness
Cumbria
LA14 2LB

MAKING AN URGENT REQUEST\REFERRAL

South Cumbria CAMHS have a Crisis and Intervention Service (CAIS) which can offer urgent support in cases where a young person/child:

> **is an inpatient on a hospital ward and requires urgent clinical assessment in respect of an eating disorder, suicide\suicidal ideation\attempted suicide, overdose or self-harm**

To make an urgent request for involvement\referral for a child\young person for the reasons detailed above, please contact our CAIS team on 01228 603964.

For referrals which do not require immediate response, but are deemed to be high priority, please email a referral form to the email address above as follows:

- In the email subject, please detail **'URGENT REFERRAL'**
- If sending the referral by email, attach a high importance marker **'!High Importance'**
- Please phone CAMHS on 01229 402696 to advise that you are sending an urgent request for service\referral for processing.

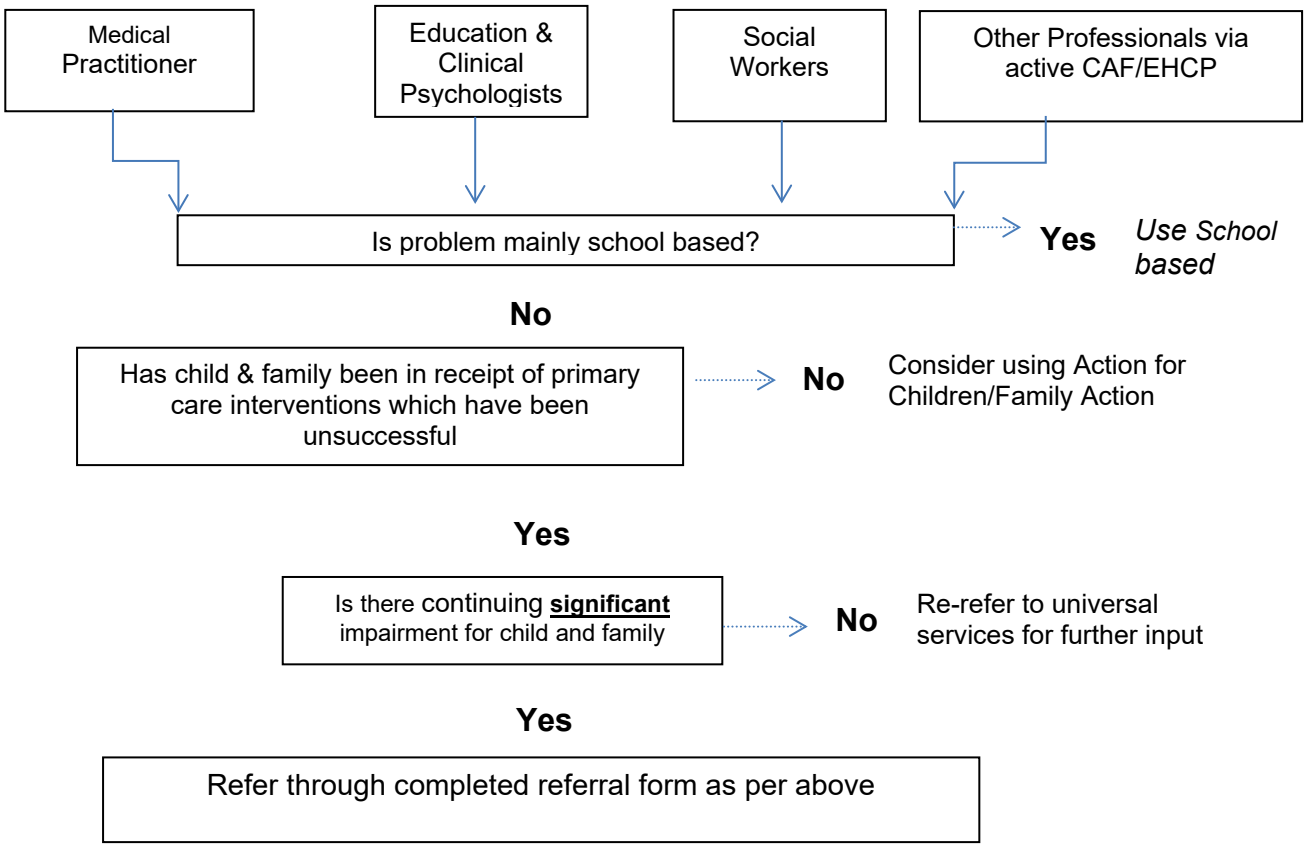
Once an urgent referral is received it will be passed to our triage team for clinical triage in order that arrangements can be made to see the child\young person as soon as possible where required, and if appropriate to do so.

If you have any queries about making a referral, please contact our business support team on 01229 402696 and a member of staff will be able to advise you regarding the action that you should take.

Child and Adolescent Mental Health Service (CAMHS) Locations

- Chorley and South Ribble
- Fylde and Wyre
- Lancaster and Morecambe
- Preston
- West Lancashire
- South Cumbria

ACCESS TO CAMHS & CHILDREN'S PSYCHOLOGICAL SERVICES FOR CHILDREN AND YOUNG PEOPLE TO 19 YEARS



ARE YOU UNSURE WHETHER OR NOT TO REFER TO CAMHS?

Ring for advice on number below

South Cumbria CAMHS

01229 402696

CAMHS is not emergency service.
In situations of urgency we will be happy to advise but where there is a high level of risk that cannot be managed or an out of hours response is required, please contact our CAIS team on 01228 603964.
In these circumstances, you should also consider making a referral to Children's Social Care.

SERVICE INFORMATION

Child and Adolescent Mental Health Service (CAMHS)

Service Information

CAMHS provides timely and appropriate access to specialist provision for children and young people with a broad range of emotional health, psychological distress and mental health disorders. We aim to provide a single route of access to our specialist services for children, young people and their families. We take referrals for children and young people up to 18th Birthday. Referrals are jointly triaged Monday – Friday by Tier 2 and Tier 3 emotional wellbeing and mental health services.

Tier 3 Child and Adolescent Mental Health Services (CAMHS) is a specialist mental health child psychiatry service. It accepts referrals for cases which require complex multi-disciplinary interventions or psychiatric input. It is expected that there will have been a range of primary and/or Tier 2 interventions before Tier 3 CAMHS become involved in a young person's care. This intervention may, for example, come from the services such as Health Visiting, Strengthening Families, School Counselling, Schools, Children's Social Care, Looked After Children Services or Children's Centres.

Referral Routes

A single referral process has been developed so that requests for involvement\referrals can be directed and allocated to the most appropriate service, whilst taking account of clinical need.

Who Can Refer?

We accept requests for involvement\referrals from Doctors (including GP's and Paediatricians), Psychologists (Educational and Clinical), Social Workers and other professionals. Self-referrals are also now available via the Healthier Lancashire & South Cumbria website https://www.healthyyoungmindslsc.co.uk/home/south-cumbria-camhs-self-referral

Referral Criteria and Exclusion

CAMHS has exclusion criteria, such as difficulties not suitable for CAMHS interventions, or which are not commissioned to be provided. These vary slightly between services but the principles remain the same. Please contact our business support team to discuss further if you are unsure whether to refer or not. We are happy to discuss possible requests for involvement\referrals and offer advice and guidance on cases with you so that you can make the most appropriate decision for the child, young person and their family.

Believe in children
Barnardo's

Child and Adolescent Mental Health Service (CAMHS)
REFERRAL FORM

INADEQUATELY COMPLETED FORMS AND UNJUSTIFIABLE REQUESTS WILL BE RETURNED TO THE REFERRER

This referral form is for access to services incorporating Primary Mental Health Early Intervention and CAMH Services which are jointly delivered by Lancashire and South Cumbria NHS Foundation Trust and Barnardo's across Cumbria. Your referral will be reviewed by representatives from both organisations. Onward referral to other agencies will be completed on your behalf where clear consent is included on this form.

PATIENT DETAILS:		**Referral Date:**
SURNAME:	**DOB:**	**PRACTICE:**
FIRST NAME:	**AGE:**	
NHS NUMBER:	**ETHNICITY:**	
GENDER:	**RELIGION:**	
ADDRESS: **EMAIL:**		**Tel:** **Fax:** **Practice code:** **Registered GP:**
PHONE: Home: Mobile: Work:		**INTERPRETER REQUIRED?** (if yes, state language including signing) YES ☐ NO ☐
NAME OF PERSON WITH PARENTAL RESPONSIBILITY (if different from the contact details above) : **ADDRESS:**		**CONTACT DETAILS** **PHONE:** **EMAIL:**
SCHOOL (if known):		Is attendance an issue? DON'T KNOW ☐ YES ☐ NO ☐

DISABILITY (if yes, provide details):	YES ☐ NO ☐
Is the child/young person "looked after" as defined in the Children's Act 1989?	YES ☐ NO ☐
Is the child/young person adopted?	YES ☐ NO ☐
Are there safeguarding concerns about the child/young person or family? (if yes, provide details)	YES ☐ NO ☐
Is the child/young person subject to a Child Protection Plan?	DON'T KNOW ☐ YES ☐ NO ☐

OTHER SERVICES / PROFESSIONALS INVOLVED (if known):		
Name	**Agency**	**Contact Tel No**
Has an Early Help Assessment been completed?		YES ☐ NO ☐

FURTHER HELPFUL INFORMATION:	
Does the parent or carer have any known literacy problems? (if yes, provide details)	YES ☐ NO ☐
Do the parents/guardians have parental responsibility?	YES ☐ NO ☐
Are the parents/guardians agreeable to the referral?	YES ☐ NO ☐
Has the child/young person been seen as part of the referral?	YES ☐ NO ☐

REFERRAL DETAILS:
Reason for the referral:
When did the problems start?

SIGNIFICANT MEDICAL HISTORY:

CURRENT MEDICATION:

ALLERGIES:

RISK ASSESSMENT:

Are there any issues that place this young person or others at risk? (if yes, provide details) YES ☐ NO ☐

AGREEMENT TO REFERRAL:

The information on this form will be used to assess the emotional and mental health needs of the referred child/young person. Sometimes we may be able to **re-direct** the referral to a more appropriate service if consent is obtained to share the information with other agencies.

Have the parents/guardians given consent to allow CAMHS to share information as specified above? YES ☐ NO ☐

REFERRER DETAILS:

REFERRER'S NAME:

REFERRER'S DESIGNATION:

REFERRER'S ORGANISATION:

TEL:

EMAIL:

SIGNATURE:

DATE:

CEDS Referral Form Triage Prompt Questions

If you are referring a young person with a suspected eating disorder please complete this page

Does the young person present with a suspected eating disorder? *Do they appear to have body image distortion? Are they deliberately attempting to lose weight in an unhelpful way, particularly if weight loss is not clinically indicated? Include an eating disorder diagnosis if this has been given.*
What is the young person's current weight and height? And do they have a history of weight loss? *If so, please give details including the current rate of weight loss.*
Is the young person currently restricting their food or fluid intake? I*f yes, please give details. If malnutrition or dehydration is suspected, please include details of any physical health symptoms*
Does the young person report binging (eating large volumes of food in a short space of time) episodes? *If yes, please give details.*
Does the young person report any compensatory behaviours to control or reduce their weight – these include vomiting, laxatives, excessive exercise, diet pills? *If yes, please give details.*
For any suspected eating disorder, an assessment of physical health risk is essential. Please consider when the young person last saw their GP and consider requesting an urgent appointment to check the following according to Junior MARSIPAN Guidelines: blood biochemistry (full FBC's, U's and E's, Potassium, Magnesium, Phosphate, LFT's), blood pressure standing and sitting, temperature, pulse rate, weight and height and attaching these results to the referral. Seeks guidance from CEDS clinicians if you are unsure.

SEND REQUEST TO:		**Tel Number**	**Email**
☑ **South Cumbria**:	Alfred Barrow Health Centre, Duke Street, Barrow-in-Furness,Cumbria, LA14 2LB	01229 402696	camhssouth@nhs.net