Rotherham CAMHS Referral Form

Fax to: 01709 302547

Rotherham Doncaster and South Humber NHS Foundation Trust

REFERRER'S DETAILS			
Date of referral:		Time of referral:	
Name of referrer:		Contact number:	
Status of referrer:			
Address of referrer:			
Informed consent: Yes ☐ No ☐			

CLIENT'S DETAILS					
Name:		Date of birth:		NHS No.	
Address					
Postcode:		Telephone:		Mobile No.	
Preferred contact:		Consent given to contact by telephone? Consent given to contact by Letter? Consent given to contact by text message?		Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	
Religion:		Ethnicity:			
Interpreter required:	Yes ☐ No ☐	If Yes please state language:			
Details of person with parental responsibility if under 16:	(Name, address and telephone number)				

CLINICAL DETAILS
Reason for referral:
Is the patient currently Suicidal? Yes ☐ No ☐ Actually self-harming? Yes ☐ No ☐
Has the patient a history of drug/alcohol usage? Yes ☐ No ☐ (if yes please provide information, name of substance, frequency, route taken, e.g. I.V. Oral, Smoked, Sniffed)

History of self harm: Yes ☐ No ☐	History of violence: Yes ☐ No ☐
Dangerous behaviour /risks to staff and others? Yes ☐ No ☐	
Previous psychiatric history (known to Rotherham services or other services)	
Current medication (if applicable)	
CLINICAL DETAILS (CONTINUED)	
Previous CAMHS involvement: Yes ☐ No ☐ Unknown ☐	
Relevant Information (including current and previous interventions from universal services):	
Does the young person have an identified learning disability? Yes ☐ No ☐ (if yes please give details)	
Other known medical problems/disabilities? Yes ☐ No ☐	
If yes, please give details:	
Legal Status (e.g. LAAC):	

OTHER INVOLVED PROFESSIONALS	
General Practitioner:	
Health Worker (if applicable)	
School Name (required)	
CAF Completed?	Yes ☐ No ☐
FAMILY	
Patient's family informed? Yes ☐ No ☐ Young person informed? Yes ☐ No ☐ *****If not, this referral cannot be processed*****	
Any safeguarding concerns?	
ADDITIONAL INFORMATION	
Do you consider the young person/child as high risk? Yes ☐ No ☐	
Preferred venue for initial appointment:	
Home visiting risk? Yes ☐ No ☐	

<u>THANK YOU FOR COMPLETING THIS FORM</u>

If you would like to discuss this referral, please contact the CAMHS Duty Team on 01709 304808

Please send to:

Rotherham CAMHS
Kimberworth Place
Kimberworth Road
Rotherham
S61 1HE