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| Please e-mail this form to afcbsmdd.bsm.dd@nhs.net**Before completing a referral please note the following;** * We are a short-term service providing support to children and young people who are experiencing mild to moderate mental health issues and their families.
* We are not a crisis intervention service.
* For primary school aged children, we generally provide support to parents rather than working with children directly. This is because the evidence suggests that this is more effective than 1:1 short term interventions for this group of children.
* Derbyshire and Derby City CCG commission and fund two early intervention early help services in Derbyshire - Build Sound Minds and Changing Lives. Please note that referrals submitted on this form may be directed to either of these services.
* We will be unable to accept referral forms which are not fully completed.
 |
| **Data Protection and Consent:**  |
| **All referrals** | ***Yes*** |
| Action for Children is part of a community triage process with other services across Derbyshire and Derby City to ensure children and families receive the most appropriate support from the right service. These other services are from Health, Social Care, Education and the Voluntary Sector. Please tick to say you either are the parents or that you have discussed this with parents and you/they give consent for us to share the information contained within this referral form with these agencies. Please leave blank if you/they do not consent to this. | [ ]  |
| *Please ensure that you are able to answer “yes” to all the statements below appropriate to the child’s age on the date of referral. Unfortunately if you are not able to answer “yes” to any of these we will be unable to accept or process the referral.* |
| **Children aged 7 years and under**: | ***Yes*** |
| The parent/carer has given their consent for a referral to Action for Children to be made and that this will involve direct work with the whole family system. | [ ]  |
| The parent/carer is aware of the personal details contained in this form (such as names, dates of birth, contact details and referral information) and has given their consent for Action for Children to hold these and use them to contact them to discuss the referral in more detail. The parent/carer is aware that personal information may be checked against the NHS central database. | [ ]  |
| **Children/Young People aged 8 to 15**: | ***Yes*** |
| The child/young person is aware of the referral and what the service will mean to them. -OR-The child/young person is not able to be aware of the referral and what the service will mean to them for the following reason:       | [ ]  |
| The parent/carer has given their consent for a referral to Action for Children to be made and that this will involve direct work with the whole family system. | [ ]  |
| The parent/carer is aware of the personal details contained in this form (such as names, dates of birth, contact details and referral information) and has given their consent for Action for Children to hold these and use them to contact them to discuss the referral in more detail. The parent/carer is aware that personal information may be checked against the NHS central database. | [ ]  |
| **Young People aged 16 and over**: | ***Yes*** |
| The young person is aware of the referral, what the service will mean to them and has given their consent for it to be made.  | [ ]  |
| The young person is aware of the personal details contained in this form (such as names, dates of birth, contact details and referral information) and has given their consent for Action for Children and The Derbyshire Federation for Mental Health to hold these and use these to contact them to discuss the referral in more detail. The young person is aware that personal information may be checked against the NHS central database. | [ ]  |

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| **The Child/Young Person:** *A separate referral form will be required for each child referred.* |
| Forename(s): |       | Surname: |       |
| Likes to be called: |       | Date of Birth: |       |
| Gender: |       | Ethnicity: |       |
| Is gender identity same as assigned at birth? | Yes: [ ]  No: [ ]  |
| Preferred Pronouns? |       | NHS Number:*if known* |       |
| Address |       |
| Postcode: |       | Email Address: |       |
| Mobile Number: |       |
| Preferred method of communication: | Telephone: [ ]  Email: [ ]   | *Please note that at times will may need to communicate via both these methods* |
| Child Protection: | Yes, currently: [ ]  Yes, historically: [ ]  No: [ ]  |
| Child in Need: | Yes, currently: [ ]  Yes, historically: [ ]  No: [ ]  |
| Child in Care/Entering Care: | Yes: [ ]  No: [ ]  |
| Disability:*Select all that apply.* | Hearing: [ ]  Learning Difficulties: [ ] Mobility: [ ]  Sight: [ ]  Speech: [ ]  Other:       |
| Other significant factors:*Select all that apply.* | ADHD: [ ]  ASD: [ ]  Young Carer: [ ]  CYP Substance misusing: [ ] Asylum Seeker: [ ]  Migrant CYP: [ ]  Young Offender: [ ]   |
| Name(s) of person(s) with parental responsibility:*Please ensure that full contact details are included below.* |       |
|  |
| **Parent(s) or Carer(s) 1:**  |
| Name: |       | Relationship: |       |
| Mobile Number: |       | Landline Number: |       |
| Email Address (please include wherever possible): |       |
| Preferred method of communication: | Telephone: [ ]  Email: [ ]   | *Please note that at times will may need to communicate via both these methods* |
| **Other children living in the household:** |
| Name child 1 | DOB Child 1 | Name Child 2 | DOB Child 2 |
|       |       |       |       |
| Name child 3 | DOB Child 3 | Name Child 4 | DOB Child 4 |
|       |       |       |       |
|  |  |
| **Parent(s) or Carer(s) 2:**  |
| Name: |       | Relationship: |       |
| Mobile Number: |       | Landline Number: |       |
| Address: |       |
| *Address only required if different from those given for child/young person above* |
| Email Address (please include wherever possible): |       |
| Preferred method of communication: | Telephone: [ ]  Email: [ ]   | *Please note that at times will may need to communicate via both these methods* |
|  |  |
| **Any Other Significant Members of the Household/Family Network:** *e.g. step-parents, grandparents etc. Contact details only required where these are different from those given for the Child/Young Person above* |
| Name: | Relationship to child: | Address or Email address: | Telephone Number: |
|       |       |       |      |
|       |       |       |       |
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| **Are there any further Issues about the Child/Young Person or the Family that we need to be aware of:** |
| What is the families preferred language: |       |
| Is an interpreter required for communications in English: If yes, p*lease specify which language.* |       |
| Problems with literacy: |       |
| Physical, Sensory or Learning Difficulties: |       |
| Issues relating to ethnicity or culture: |       |
| Issues relating to gender or sexuality: |       |
|  |
| **GP/Medical Practice:** *As our service is funded by Derbyshire and Derby City CCG we need details of the young person’s registered GP/Medical Practice in order to confirm their eligibility for the service.* |
| GP Name (if known): | Medical Practice: | Address or E-mail Address: | Telephone Number: |
|       |       |       |       |
|  |  |  |  |
| **Other Significant Medical Professionals involved (if not referrer):** *Please list any other significant medical professionals involved with the young person e.g. paediatrician, CAMHS, School Health Service etc.* |
| Name: | Agency: | Address or E-mail Address: | Telephone Number: |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
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| **School:**  |
| Child is: | Registered with school: [ ]  Home schooled: [ ]  Under School age: [ ]  *If child is home schooled or under school age, please skip the rest of the questions below* |
| School: |       |
| Address: |       |
| Postcode: |       | Telephone Number: |       |
| Email Address: |       |  |  |
| Attendance: | Attending: [ ]  Not Attending: [ ]  Excluded: [ ]   |
| **Significant Contacts:** *Please list any significant contacts within school e.g. Head Teacher, Head of Year, Class Teacher, Pastoral Manager, SENCO etc.* |
| Name: | Role: | E-mail Address: | Telephone Number: |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|   |
| **Other Significant Agencies:** *Please give details of any other relevant agencies providing support to the family or young person not already listed above e.g. Social Worker, Other Support services etc.* ***Please also note if they are on the waiting list for any other services, e.g. CAMHS*** |
| Name: | Agency: | Address or E-mail Address: | Telephone Number: |
|       |       |       |       |
|       |       |       |       |
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| **Main presenting problem:** *Please select the* ***ONE*** *main reason for referral from the list below.* |
| Adjustment to health issues: | [ ]  | Anxiety: | [ ]  | Attachment difficulties: | [ ]  |
| Bullying: | [ ]  | Challenging Behaviour: | [ ]  | Diagnosed Autism Spectrum Disorder: | [ ]  |
| Drug and Alcohol Difficulties: | [ ]  | Eating Disorders: | [ ]  | Gender Discomfort Issues: | [ ]  |
| Low Mood: | [ ]  | Neurodevelopmental Conditions, excluding ASD: | [ ]  | Phobias: | [ ]  |
| Trauma: | [ ]  | Relationship Difficulties: | [ ]  | Self Esteem: | [ ]  |
| Self-harm behaviours: | [ ]  | Suspected Autism Spectrum Disorder: | [ ]  | Unexplained Physical Symptoms: | [ ]  |
|  |  |  |  |  |  |
| **Current Issues for the Child:** *Please select* ***ALL*** *that apply and give details below.* |
| Difficulty making relationships: | [ ]  | Help managing/understanding child: | [ ]  | Problems with eating: | [ ]  |
| Reaction to separation and loss: | [ ]  | Mild/moderate anxiety symptoms: | [ ]  | Problems attending school: | [ ]  |
| Difficulty managing behaviour: | [ ]  | Reaction to trauma, including abuse: | [ ]  | Problems at school: | [ ]  |
| Mental health concerns: | [ ]  | Problems with toileting/smearing: | [ ]  | Low level self-harm: | [ ]  |
|  |  | Insufficient stimulation at home: | [ ]  | Other: | [ ]  |
| Please give details: |       |  |
| **Current Issues for the Family:** *Please select* ***ALL*** *that apply and give details below.* |  |
| Bereavement: | [ ]  | Domestic Abuse: | [ ]  | Family Violence/Conflict: | [ ]  |
| Separation/Divorce: | [ ]  | Loss: | [ ]  | Homelessness: | [ ]  |
| Parental Drug/Alcohol Issues: | [ ]  | Parental Mental Health (medicated): | [ ]  | Poor Housing Conditions: | [ ]  |
| Parental Learning Difficulties: | [ ]  | Long term physical health issues: | [ ]  | Other: | [ ]  |
| Please give details: |       |  |
|  |  |  |  |  |  |
| **Historic Issues for the Family:** *Please select* ***ALL*** *that apply and give details below.* |  |
| Bereavement: | [ ]  | Domestic Abuse: | [ ]  | Family Violence/Conflict: | [ ]  |
| Separation/Divorce: | [ ]  | Loss: | [ ]  | Homelessness: | [ ]  |
| Parental Drug/Alcohol Issues: | [ ]  | Parental Mental Health (medicated): | [ ]  | Poor Housing Conditions: | [ ]  |
| Parental Learning Difficulties: | [ ]  | Long term physical health issues: | [ ]  | Other: | [ ]  |
| Please give details: |       |  |
| **Tell us about the child**. *Include a description of difficulties, measures taken to address them, any sufficient history, other services involved (currently or previously) and the impact these have had.* |  |
|       |
| **What help are they asking for?** |  |
|       |
| **What are the child’s views on this referral? Please share this below or ask them to share this if they are able.** |
|       |
|  |  |
| **The Referrer:**  |
| Agency/School: |       |
| Name: |       | Role: |       |
| Address: |       |
| Postcode: |       | Telephone Number: |       |
| Email Address: |       |  |  |
| How long have you known the child/young person: |  |
| Has the family had an Early Help Assessment completed in the last 12 months?  | Yes [ ]  If yes, please attach with the referralNo [ ]  |
| **Referrers Agreement** |  |
| By signing this document, you are confirming that you have accurately completed this form to the best of your ability and have answered “yes” to the appropriate data protection and consent statements above. | Signed: |       |
| Print Name: |       |
| Date: |       |
| *Please note referrals submitted electronically do not need to be printed and signed. We will take submission by email as electronic signature assuming name and date are completed above.* |
|  |