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| Mental Health Support Team - Schools Referral Form |

Mental Health Support Team - Schools (MHST)

Christopher Wren House, 113 High St, Croydon, CR0 1QG

**Email:** CroydonMHST@slam.nhs.uk

**Schools referrals to be discussed in the first instance with MHST staff – Schools Practitioner or EWP attached to the school. Then referral form to be emailed to** [CroydonMHST@slam.nhs.uk](mailto:CroydonMHST@slam.nhs.uk)

**Please ensure that all young people are aware of their referral when appropriate to their age and developmental stage. Parental consent is required for all young people aged 15 years and below other than in exceptional circumstances. Young people aged 16 or 17 years must provide their own consent.**

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| **\* Date of Referral** | | |  | | |
| **\* Do the parents/carers understand why this referral is being made and has verbal consent been obtained? Please ask parents to sign if possible.**  **If consent has not been obtained, please indicate why?** | | | Yes / No | | |
| Parent’s Signature | | |
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| **\* Have you spoken with the child or young person on their own?**  **If so, do they agree to this referral being made?** | | | Yes / No | | |
| Have the family completed a consent form giving us permission to contact other agencies? | | | Yes / No | | |
| Is the child subject to a child protection plan or are they a child in need? | | | Yes/ No | | |
| Is the child Looked After by a local authority?  (living with a foster carer or otherwise in care) | Yes / No | Responsible Local Authority |  | | |

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| **Referrer’s Details** | | | |
| **\* Name** |  | | |
| **\* Job Title** |  | | |
| **\* Organisation** |  | | |
| **\* Address** |  | | |
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| **\* Tel. No.** |  |  |  |
| **\* Email** |  | | |

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| **Details of Child / Young Person** | | | |
| **Name** |  | **Date of Birth** |  |
| **Address** |  | Gender |  |
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| Mobile (parents) |  | Mobile (young person) |  |
| Email address |  | Young Person Email |  |

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| **Risk Management** | | | |
| **\*** Are any of the following an issue for the young person?  Please provide us with specific details to allow us to assess current risks to the child/young person. If you feel the child/young concern is likely to need an urgent CAMHS assessment, please also make a telephone referral. | | | |
| Self-Harm requiring minimal intervention  e.g. Type of self harm, frequency, date of last incident, number of total incidents. | 🞏 |  |  |
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| Self-Harm requiring medical intervention  e.g. Type of self-harm, frequency, date of last incident, number of total incidents. | 🞏 |  |  |
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| Suicide Attempts | 🞏 |  |  |
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| Suicidal Ideation | 🞏 |  |  |
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| Risk to Others | 🞏 |  |  |
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| Eating Disorder  **\*** Please ensure height & weight are recorded | 🞏 |  |  |
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| Drug / Alcohol Abuse | 🞏 |  |  |
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| Safeguarding or child protection issues  Referrers should follow up any child protection concerns they have as per local policy and procedure | 🞏 |  |  |
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| **\*** Are any of the following a potential issue for the young person? | | | |
| Attention Deficit Hyperactivity Disorder | 🞏 | Autistic Spectrum Disorder | 🞏 |
| Physical Disability | 🞏 | Learning Disability | 🞏 |
| Behavioural Difficulties | 🞏 | Depression/Emotional Disorder | 🞏 |
| Please include Educational Psychologist reports if the child / young person is being referred in relation to possible ADHD or Autistic Spectrum Disorder. We are not able to accept these referrals without an Educational Psychologist assessment. | | | |

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| **Reason for Referral**  Please attach additional sheets if you need more space | | | |
| **\*** What is the problem you are seeking help with? Please explain how long these difficulties have been present.  Please provide as much information as possible. Please explain why you feel the child/young person may have a moderate-severe mental health problem or a Neurodevelopmental Disorder.  Please include: How mental health issue is impacting daily functioning, Any recent changes in their life etc | | | |
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| **\*** What has already been tried?  Please attach any multidisciplinary assessment reports (e.g. Paediatrician, Educational Psychologist, Speech & Language Therapist etc) | | | |
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| **\*** What assessment or intervention is requested from the MHST service?  e.g. Anxiety Intervention, Low Mood Intervention, Behavioural Management Intervention, consultancy and advice. | | | |
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| **\*** What is the Parent/Carer or Young Person’s view of the problem? | | | |
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| **\*** Has the child/young person experienced any difficulties in the past?  If yes, please detail issues and action taken | | Yes / No | |
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| **Equality of Access**  **.** | | | | | | |
| Main language spoken by child | |  | | | | |
| Main language spoken by parents/carer | |  | | | | |
| Interpreter required and for whom | |  | | | | |
| Ethnicity | |  | | | | |
| We would like to support all families to access our services. Please let us know if this family requires help around access e.g. physical access, language (incl. British Sign Language) or literacy. | | | | | | |
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| Does the child/young person referred have Special Educational Needs / Disability / Learning Disability?  If yes, please provide details and attach accompanying reports. | | |  |  | |  |
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| **Other Members of the Family**  (e.g. parents / carers / siblings / significant others) | | | | | |
| Name | | Relationship | Occupation/School | Living with child? | Age or DoB |
| Parents / Carers |  |  |  |  |  |
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| Who has legal parental responsibility? | | | | | |

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