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| **Mental Health Support Team** **MHST** **The Referral Form**If you have any doubt about this referral or need help to complete it please contact a member of the Team and we would be happy to help you.ConfidentialityIf you are a professional, please discuss this referral with the child/young person and their parent(s) or carer(s). It may be necessary to share information with other professionals so that we can offer the best service to the family.During the course of their care, some details may be recorded digitally. For your protection, the use of this data is controlled in accordance with the Data Protection Act, 1998.

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| CHILD/YOUNG PERSON’S DETAILS |
| Full Name: Date of Birth: Preferred Name: Sex:Preferred Pronoun: Gender Identity:  |
| Contact number:  |
| Address (including Post Code): |
| GP Surgery: |
| Name of School: School Year: |
| Please provide details of any additional educational needs/support offered *(EHCP, 1-1, ELSA etc)*: |

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| Living with parents*Please provide details:* | Living with relatives*Please provide details:* | Other*Please provide details:* Looked After Child Subject to Child Protection Plan Adopted |
| First Language: Interpreter Required?Yes No If yes, which language? |
| Does the child/young person consider themselves to be transgender? Yes No Not asked | Sexual Orientation: Heterosexual Gay Lesbian Bisexual Prefer not to say Other………………………… |
| Does the child / young person have a disability? Yes No*If yes, please specify:* | Does the child / young person have a:Visual Impairment Yes No  Hearing Impairment Yes No  *Please add details relevant to be aware of prior to an appointment:* |

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| REFERRER DETAILS |
| Name of referrer: Job Title: |
| Date of referral: |
| Referrer work address: |
| Contact number and email address: |

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| PARENT/CARER DETAILS  |
| **1.**Name of main carer/s: Parental Responsibility?   |
| Relationship to child: |
| Address (if different to child/young person):  |
| Contact Number: |
| Email Address: |
| **2.**Name of Carer: Parental Responsibility? |
| Relationship to child: |
| Address: |
| Contact Number: |
| Email Address: |
| Is there any history of parental mental health difficulties and or substance misuse?*If yes, please specify:* |
| Are any adult services currently involved?*If yes, please specify:* |

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| CURRENT AGENCIES INVOLVED *(i.e. social care, early, help, school nurse etc)* |
| **1.**Name and Role: |
| Contact Number & email address: |
| Details of involvement: |
| **2.**Name and Role: |
| Contact Number & email address: |
| Details of involvement: |

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| MENTAL HEALTH CONCERNS |
| Reason for referral – what are the presenting concerns?(*What is the currently going on for the young person? How long has this be a concern for? Has something changed that may have triggered this?)*  |
| How is the above impacting on the young person?*(Has this stopped the young person from doing anything that they used to do/or that they want to do?)* |
| What is/are the current presenting risks? How is this being managed by family and school?*(Who is at risk? Is this a new risk? What professionals/family have been informed?)* |
| What interventions have been attempted to date?  |
| What input are you hoping for from the MHST?*(What is the young person hoping for? As the referrer what would you like to happen as a result of this referral?)* |

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| REFERRAL CONSENT  |  |
|  | If no, please give reason |
| Is the parent aware of the referral? |  |
| Does the Child / Young person consent to the referral? |  |
| Does the Child / Young Person / Parent / Carer give consent to discuss this referral with appropriate external services e.g. Children’s Services, Education, Voluntary sector?  |  |

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| ADDITIONAL INFORMATION |
| Anything else that may be helpful for us to know?*(Neurodevelopmental diagnosis, substance use, medication, environmental factors etc)* |

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| **Please return completed referral to** **MHSTCamhsPortsmouth@solent.nhs.uk***\*Please be aware that sending by email from iCloud, Hotmail, Live, Yahoo or other private email accounts to nhs.net is not secure.* |

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