

**Bury Child & Adolescent Mental Health Service (CAMHS)**

**Single Point of Entry Referral Form -**

Any professional with concerns regarding a child’s mental health/wellbeing can make a referral to CAMHS. We are using a CAMHS Single Point of Entry (SPOE) referral form. We are a SPOE for the following services:

* **CAMHS** (core, neurodevelopmental, link worker and transitions teams)
* **Mindfulness and Holistic at Early Break**
* **Streetwise counselling (for ages 14-16)**
* **Loss and bereavement at Early Break**
* **First Point parenting/family support**
* **First Point post diagnostic workshops for diagnosed ADHD and ASC**

Please note it is the referrer’s responsibility to ensure the family are aware we are a SPOE service and the referral will be directed to the most appropriate service listed above, some of which are outside of the NHS, or we may advise for you to refer externally.

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| **Name: D.O.B.: Age** **NHS no: Ethnicity: Gender :** **Family’s first language: Is an interpreter required?** YES 🞏 NO  **Current Address: Current School:** **Tel:** **GP Name& Practice address: Tel:** Does the child have a statement of special educational need? YES NO 🞎 Details………… ………………………………………………….Has / Is the young person accommodated by a Local Authority? YES 🞏 NO Child's legal status …………………………..Is/Has the young person on the Child Protection Register? YES 🞏 NO If yes, please supply additional information. |
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| **Names of Parents / Carers:** **Siblings:** **Are any Siblings involved in other services:**YES 🞎 NO 🞏 - If Yes please provide information***REQUIRED FOR REFERRAL:*****Parent/Carer has been informed that in making a referral to the Single Point of Entry (SPOE), the referral will be passed to one of the agencies listed at the top of this referral form, and that some of these agencies are outside of the NHS**: YES 🞏 NO 🞏**Parent / Carer understands what information is being provided as part of the referral**:  YES 🞏 NO 🞏**Parental consent/agreement to SPOE referral:** YES 🞏 NO 🞏    |

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| CURRENT NEEDS/ Difficulties / Concerns & PLAN OF CARE**(Include CAF, copy of assessment reports, care plan and/or recent clinic letter(s)****Duration of : - 0-6 months 6-12 months 12+** |
| ***CURRENT MEDICATION*** **(include dosage)** |
| ***HOW SOON DOES CHILD NEED TO BE SEEN*****(Consider risk, medication and current frequency of contact of other parties involved)** |

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| OTHER AGENCIES INVOLVED  | CURRENT INV (Tick) | PAST INV (Tick) | Contact Name and Number | INVOLVEMENT SUMMARY(what have they done?) |
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| **Referrer Name: Agency:** **Contact Details:****Signature of Referrer: Date** |

**Send Referral via email to:**

pcn-tr.burycamhscypiapt@nhs.net

**or via post to:**

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

**Fairfield General Hospital, Rochdale Old Road,**

**Bury BL9 7TD**

**Tel: 0161 716 1100**