

Seamless Point of Access (SPoA) Child and Adolescent Mental Health Services Referral Form

OFFICE USE ONLY Date / Time Received:
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It is important you provide us with as much information as possible to enable the referral to be triaged. Please ensure you have consulted with CAMHS Duty (01874 615662) and/or Powys CAMHS Schools In-Reach Team powyscamhs.schoolsin-reach@wales.nhs.uk

Tel: [REDACTED] -Separate referral for this service) before submitting. We are available Monday-Friday 9am-5pm

Please email referrals to: POWYS CAMHS: powyscamhs.admin@wales.nhs.uk

An asterisk (*) indicates this information **must** be provided

To place an **X** in the relevant box - double left click, click 'check' and 'ok'

*Child's Surname:		*Forename(s):	
*Date of Birth:		Age:	*First Language: *Interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/>
*Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	NHS No:		WCCIS No:
Gender Identified as:			
*Main Residence Address:		*Postcode:	
*Telephone Numbers:			
Alternative Address and tel. number (if relevant):			
*Name of person(s) with parental responsibility giving consent to referral	*Relationship to child	*Address and contact telephone number & email (if different from child)	
Is the YP aware of the referral: Yes <input type="checkbox"/> No <input type="checkbox"/> *IF NO-PLEASE CONSULT WITH US AGAIN BEFORE SUBMITTING*			
Are the parents/carers aware/consent to referral? Yes <input type="checkbox"/> No <input type="checkbox"/>			
You must also indicate if they are asking for a confidential service i.e. without parent/carer knowledge: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Names of other significant adults	Relationship	Address and contact telephone number, if different from child	

***Are there any special arrangements/issues to be aware of when contacting the carer/young person?**

Yes No Don't know Details:

***Are there any specific issues with communication/literacy for the parent/carer or young person?**

Yes No Don't know Details:

***GP Name:**

***GP Surgery:**

***Nursery/School/College:**

Tel. Number(s):

Head Teacher:

Class Teacher:

ALNCO:

School Nurse:

Tel. Number(s):

Other services currently involved:

***Does the Child or Young person have an allocated Social Worker? If yes, please provide Name and Contact Details.**

Is the Social Worker aware this referral is being made? Yes No

***Legal status, please tick relevant box**

Care of parent

Care of Local Authority: Powys

Other (Please state):

Section 76, Voluntary Accommodated

Full Care Order

Interim Care Order

Care Order, placed with friends or relatives

Child Protection Plan

***REASON FOR REFERRAL**

What are the difficulties? How long have they been present? How do they impact on the child/young person's life and their family? What is the intensity of the difficulties?

If you have any concerns regarding a suspected eating disorder, please include the following.

(Please Note: If you are unable to provide the following please advise the parent/carer to attend their G.P with the young person)

1. Current height and weight measured without footwear by a health professional (rather than self-reported)
2. Any available historic weights – This will help us assess the rate of weight loss.
3. Lying *and then* standing pulse rate
4. Lying *and then* standing blood pressure
5. Temperature

Please list the impact that the child/young person's difficulties are having on their nursery placement, education, or workplace:

Please state what interventions have already been delivered in respect of these difficulties: (e.g. ELSA, THRIVE, YIS, SilverCloud, Ed Psych/ALNCO/ consult or School based counselling). If other interventions have not been considered, please provide rationale:

*Known risks regarding child/young person:	Past	Present	
Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Misuse	<input type="checkbox"/>	<input type="checkbox"/>	
Criminal behaviour	<input type="checkbox"/>	<input type="checkbox"/>	
Risk to others (violent, sexualised etc)	<input type="checkbox"/>	<input type="checkbox"/>	
Bullying	<input type="checkbox"/>	<input type="checkbox"/>	

If yes to any of the above, please provide further information:

What actions have been taken to manage the risk? Has any safety plan been drawn up? Are parents / carers aware of risk?*

Safeguarding Concerns: Missing, Exploited, Trafficked. Please give details:
 Any safeguarding concerns **must be referred** to Powys LA Front Door CSFrontDoor@powys.gov.uk

***Are there any family concerns that could be relevant to the referral?** For example, domestic abuse, parental physical/mental health problems, parental substance misuse, bereavements etc.

***Have you completed a referral to Children’s Services?** Yes No

Date referral sent / outcome:

***Referrer Name:**

***Designation:**

*Address:	Telephone Number:
*Post Code:	*E-mail:
*Signature:	*Date:
*Please give specific dates/times when available for further (clinical) Discussion if required:	