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| **SPECIALIST AND CHILDREN’S SERVICES****SINGLE POINT OF ACCESS MULTI-AGENCY REFERRAL FORM** |

**Referrals will be accepted from any health, social care/MAT, educational (SENCO) or 3rd sector service via**

**Email:** dhcft.SPOA@nhs.net

**Post:** Single Point of Access, Temple House, Mill Hill Lane, Derby DE23 6SA

**Tel:** If you need to discuss a new or existing referral the SPOA Administrator can be contacted on 0300 7900 264

**Please Note**: The information contained in this form will be used by the Single Point of Access team to identify the most appropriate service to meet the needs of the child. The Information on this referral form shall be used in accordance with the permissions granted by you and in accordance with GDPR and the Data Protection Act 2018. Derbyshire Healthcare NHS Foundation Trust is the Data Controller for the purposes of the Act and can be contacted at Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ. The Data Controller is committed to protecting your privacy and will collect, store, use and share the data when appropriate and only for the purposes relating to this form. For a full explanation and further information on your rights please see the Data Controllers privacy notice here

<https://www.derbyshirehealthcareft.nhs.uk/privacy-policy>

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| **Patient details** |  | **Referrer** |
| Forename | Click here to enter text. |  | Name | Click here to enter text. |
| Surname | Click here to enter text. |  | Designation | Click here to enter text. |
| Address | Click here to enter text. |  | Base address | Click here to enter text. |
| Postcode | Click here to enter text. |  | Telephone no. | Click here to enter text. |
| Date of birth  | Click here to enter text. |  | Email | Click here to enter text. |
| NHS number | Click here to enter text. |  | Date of referral | Click here to enter a date. |
| School/nursery | Click here to enter text. |  |  |  |
| Home language | Click here to enter text. |  |  |  |
| Interpreter needed | Yes |[ ]  No |[ ]   |  |  |
| GP details *if not referrer* | Click here to enter text. |  | Is this a self-referral to CAMHS? | Yes |[ ]  No |[ ]

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| **Family \ carer information**  |
| Who looks after this child? In what capacity? | Click here to enter text. |
| Who has parental responsibility? | Click here to enter text. |
| Main carer name and contact number | Click here to enter text. |

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| **Consent for referral and to access medical records and share information with other agencies**  |
| Consent discussed and agreed referral |[ ]  Consent to contact next of kin |[ ]  Consent to share and gather information between services |[ ]  Who gives consent | Click here to enter text. |

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| Which other professional \ services are involved with the family? *(Please provide contact details)* |
| Click here to enter text. |
| **Referral information** |
| Main reason for referral | Click here to enter text. |
| Nature of concern | Click here to enter text. |
| How long have these problems been evident? | Click here to enter text. |
| How do these difficulties affect the child in daily life? | Click here to enter text. |
| Areas of life where concerns are evident? | School |[ ]  Home |[ ]  Social areas |[ ]
| Medical history, including diagnostic screening, if undertaken | Click here to enter text. |
| Details of any current medication | Click here to enter text. |
| Any known allergies? If yes, please give details | Click here to enter text. |

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| **Development concerns** Please give details of practitioner and parent/carer concerns |
| Click here to enter text. |

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| **Specific concerns** |
| Abuse |[ ]  Hyperactivity |[ ]  Post trauma symptoms |[ ]
| Anxiety/phobias |[ ]  Learning needs/disability |[ ]  Self harm |[ ]
| Attachment needs |[ ]  Low mood |[ ]  School exclusion or threat of |[ ]
| Behavioural problems |[ ]  Obsession +/- compulsions with fear |[ ]  Social/communication difficulties |[ ]
| Bereavement |[ ]  Parental mental health needs |[ ]  Stress |[ ]
| Eating/weight difficulties |[ ]  Peer bullying |[ ]  Substance misuse |[ ]
| Family breakdown |[ ]  Physical disability |[ ]  Suicidal thoughts/threats |[ ]
| Hearing voices |[ ]  Poor concentration |[ ]  Vocal or motor tics |[ ]

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| **Details of above concerns and anything else you think we should know** |
| Click here to enter text. |

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| **Social and family history** Include parents, siblings, relevant family circumstances and any known risks.  Please fill in Detail Section in addition to ticking boxes |
| Parent mental health concerns |[ ]  Parent physical health concerns |[ ]  Sibling physical health concerns |[ ]
| Parent disability |[ ]   |  | Sibling disability |[ ]
| Substance abuse |[ ]  Domestic abuse |[ ]   |
| **Details** and any other relevant information such as family separations, stressful life events or other experiences  | Click here to enter text. |

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| **Safeguarding**Are any of the following in place for the child? (Please provide copies) |
| Early Help Assessment(EHA)  |[ ]  Child in need support |[ ]
| Child protection plan |[ ]  Child looked after by the Local Authority |[ ]
| Does the client or family have any safeguarding concerns? (If yes, please specify) | Click here to enter text. |
| Are there any known home environmental concerns?(If yes, please specify) | Click here to enter text. |

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| **Special educational needs and disability (SEND)**Does the child have? (Please provide copies) |
| Identified SEND  |[ ]  GRIP funding |[ ]
| Education Health and Care Plan |[ ]   |[ ]

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| **Neurodevelopmental referral (i.e. concerns about possible autism spectrum disorder and/or ADHD) Note to referrer**To enable the professionals to make appropriate decisions please ensure you have enclosed the following paperwork with this referral. Failure to do so will result in the referral being returned.1. Parent/carer questionnaire completed

1. Teacher questionnaire - nursery/primary or secondary form completed

1. Vanderbilt questionnaires completed by both parent and teacher if aged 6 or over

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