





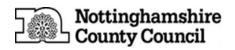
Mental Health Support Team Referral Form *To be completed by Education Staff/Mental Health Lead

Assessment and intervention will be carried out by practitioners who are engaged in an active supervision programme, for the purpose of their learning and assessment, intervention sessions may be recorded.

To receive input from the CAMHS Mental Health Support Team, we require the signed consent of the young person and their parent/carer. *If you are unable to obtain signed consent from the young person/parent/carer please ensure that you have discussed the referral and obtained verbal consent from the young person/parent/carer and clearly document this in the section below*			
Child/Young Person:			
Parent/Carer:			
Do we have permission from the young person to liaise with the parent/carer regarding this referral if required?			
Please circle as appropriate: Yes / No			
Do we have permission from the young person/Parent/Carer to liaise with relevant agencies if required?			
Please circle as appropriate: Yes / No			
Do we have permission from the young person to leave voicemails and/or sent text messages?			
Please circle as appropriate:			
Voicemail Messages: Yes / No			
Text Messages: Yes / No			
Preferred contact number/email:			
By consenting to this referral, please note that, upon screening, it may be appropriate for your referral to be passed to another team within the wider CAMHS Service.			

CHILD/YOUNG PERSON DETAILS

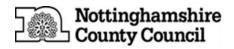
Name:		NHS Number:	
Address:		Date of Birth:	
Postcode:		School/College:	
	!	Year:	







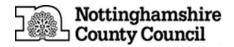
Previous Names / Alias:			I	Religion:							
GP name and	e and Ethnic Origi		า:								
address:			Ī	Nationality:							
Contact Tel. for young person:	I. for young		1	First language:		ge:					
Contact Email for young person:			Gender:								
PARENT/ CARE	<u>:R</u>										
Name Relationship		Relationship	Address (if different to child)		act Phone Nu	mber / E	mail Ad	dress			
							Phor	ne:			
							Ema	il:			
			1								
Key Presentii	ng Issue		Yes	No	1	Key F	Prese	nting Issue	Yes	No	
Mild to moderat						OCD					
Mild to Moderat	•	d				PTSE					
Mild to Moderat							I Anxi	ety			
willd to Moderal	le benavio	our dimountes			_	Phob	ia				
Existing Physic	al Health	n Conditions									
lloothioohild/											
If yes , please doctor, youth w	describe v		elow (E	Exam	ples	includ				urse,	







	Yes	No
Looked After Child		
Education Health and Care Plan		
Special Education Needs and Disabilities		
Interpreter Required		
Pupil Premium		
Young Carer		
Safeguarding/Risk/Concerns		
Please describe the impact that the difficulties ticke	ed above is having on th	ne child/YP and/or their
Please describe the impact that the difficulties ticker family.	ed above is having on th	ne child/YP and/or their
	ed above is having on th	ne child/YP and/or their
	ed above is having on th	ne child/YP and/or their
	ed above is having on th	ne child/YP and/or their
	ed above is having on th	ne child/YP and/or their
	ed above is having on th	ne child/YP and/or their







How does the young person/fan	nily feel the service would benefit them?
Name and role of referrer &	
email address:	
Date of referral:	
Referrer contact number:	
Microsoft Teams Email	
Name/Email address of school	
staff member to contact to	
make an appointment	

School Mental Health Lead to forward completed forms to CAMHS SPA: SPAReferrals@nottshc.nhs.uk

Please indicate in the email subject that the referral is for the Mental Health Support Team.

Please be aware that incomplete referrals will not be processed and will cause a delay in the child/young person receiving support- so please ensure you complete all areas of the form.

Contact number for SPA: 0115 8542299

Contact number for MHST: 0115 8760167

Email address: CAMHSMHSTTrailblazer1@nottshc.nhs.uk for queries only

If you would like to include any parental views, please do so on a separate sheet and attach to this form.