**Community CAMHS Referral Form**

**Important note to referring Referer:** Please complete all sections. Failure to provide requested information could result in a delay in assessment. Please attach any other clinical reports that are relevant to this referral.

**Details of which CAMHS Team Referral is being sent to:**

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| --- | --- |
| **CAMHS Consultant:** | **Address:** |
| **Contact No:** | **Fax No:** |
| **E-mail Address:** | |

|  |  |
| --- | --- |
| **Name of Child:** | **D.O.B:** |
| **Address:** | **Parents/Carer Contact No:** |
| **Name of Child’s G.P:**  **Practice Address:** | |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | G.P. informed of Referral |  |  | | In Writing |  |  | | By Telephone |  |  |   **Date G.P. informed:** |
| **School/Occupation:** | **Family Composition:** |
| **How long have you know the child/young person?** | **Describe the presenting problems, symptoms, when did they start and other problems identified:** |
| **What is the child/young person’s current mental state?** | **What Risk and/or resilience factors are currently present?** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Is the child/young person currently suffering from any medical problems? If so describe:** | **Has the child/young person been previously referred to:**   |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | Social Services |  |  | | Another Mental Health Service |  |  | | Psychology Services |  |  | | This Service |  |  |   **If yes to any, please provide details:** |
| **Have you obtained consent for this referral:  Yes/No** (it is advisable that consent is obtained from both parents if practicable)   |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | Both Parents |  |  | | Mother only |  |  | | Father only |  |  | | Neither parent |  |  | | Other (specify below) |  |  | | **Are there other agencies currently involved with the child/young person?**   |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | Community Care Social Work |  |  | | Paediatrician |  |  | | Community care Psychology |  |  | | Speech & Language |  |  | | Autism Services |  |  | | Child & Family Agency (Tusla) |  |  | | Others (please specify) |  |  |   **If yes to any, please provide details:** |
| **Referrer’s Name:**  **Referrer’s Clinical Discipline:** | **Referrer’s Address:** |
| **Date of Referral:** | **Contact Number:**  **Fax No:**  **E-Mail:** |