Child and Adolescent Mental Health Services

Linn Dara Community CAMHS Referral Form

Important note to referring Person:

Please complete all sections. Failure to provide requested information could result in a delay in response. Please attach any other clinical reports relevant to this referral.

Any referral to CAMHS will need a GP signature unless from another Health Professional. GP MUST be informed by referrer.

Name of Child:	DOB: / /
Address:	Gender Male ☐ Female ☐ Other: ___________________
Date of Referral:	

Parents	Name	Age	Phone No	Address if Different	Guardian	Custody	Carer
Father:					Y / N	Y / N	Y / N
Mother:					Y / N	Y / N	Y / N

Biological Parents Relationship ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐ Co-Habiting

If carers are not parents	Name	Relationship	Phone No	Address if Different	Guardian	Custody
					Y / N	Y / N
					Y / N	Y / N

Family Composition / Background	Current Risk / Resilience Factors

Presenting Mental Health Problems / Current Difficulties

Current Mental State	Medical Problems / Current Meds

Current School / Address	Year / Class	Any specific Issues related to school

Have you obtained consent for this referral? Yes / No (Please refer parents to attached Consent form for Signature) Has the child been referred before? Yes / No Date: ____/____/______	How long have you known this child: _________________ How long have you known the family: _________________ Date child seen: ____/_____/__________ Does the Family/Child need an interpreter? ______________

Are there any other agencies currently involved with the child / young person / family?

Agency / Service	**Yes**	**No**	**Report / Details Available?**
Paediatrician			
Primary Care Service			
Assessment of Need			
Disability Service			
Child & Family Agency (Tusla)			
Others (Specify)			

If yes to any, please provide further details:

Please note that Referrers to CAMHS must inform their General Practitioner of the referral. GP details need to be included.

Referrer's Name & Occupation		Gp Name	
Referrer's Address		Gp Address	
Phone Number: Fax Number:		Phone Number: Fax Number:	

Linn Dara CAMHS North Kildare
1st Floor
Primary Care Building
Maynooth Road, Celbridge
Co. Kildare, W23 YK24.

Phone No. (01) 9214002 / 03
Fax No. (01) 9214148

Linn Dara CAMHS Mid Kildare
No. 9 Sycamore House
Millennium Park
Naas
Co. Kildare, W91 DC7P.

Phone No. (045) 873880
Fax No. (045) 873897

Linn Dara CAMHS South Kildare
1st Floor
Kildare Primary Care Centre
Old Dublin Road, Kildare Town
Co. Kildare, R51 RX51.

Phone No. 0766958580
Fax No. 0766958603

Linn Dara CAMHS Ballyfermot / St. James's
Clover Suite
Linn Dara Community CAMHS Building
Cherry Orchard Hospital Campus
Ballyfermot
Dublin 10.

Phone No. (01) 7956385
Fax No. (01) 7956383

Linn Dara CAMHS Clondalkin
Bluebell Suite
Linn Dara Community CAMHS Building
Cherry Orchard Hospital Campus
Ballyfermot
Dublin 10.

Phone No. (01) 7956350
Fax No. (01) 7956427

Linn Dara CAMHS Lucan
Clover Suite
Linn Dara Community CAMHS
Cherry Orchard Hospital Campus
Ballyfermot
Dublin 10.

Phone No. (01) 7956380
Fax No. (01) 7956379

Linn Dara CAMHS West Kildare Team
1st Floor
Kildare Primary Care Centre
Old Dublin Road, Kildare Town
Co. Kildare, R51 RX51.

Phone No. 0766958585
Fax No. 0766958603

Child and Adolescent Mental Health Services

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

PARENTAL CONSENT FORM

Sometimes it might be useful for us to talk to other people who know your child well before you attend. If you are happy for us to do this, please tick and add the name of the person/school below.

☐ My child's School ____________________

☐ Public Health Nurse ____________________

☐ Social Worker ____________________

☐ Primary Care Service ____________________

☐ Counselling Service ____________________

☐ Disability Service ____________________

☐ Other ____________________

Please Note:-

- **It is our practice to request written consent from both parents**
- **It is our practice to invite both parents to appointments.**
- **Where parents are separated it is important that both parents are informed of the referral to our service.**
- **Where parents wish to be seen separately we can offer different appointment times.**

Biological Parents Relationship

☐ Married ☐ Separated
☐ Divorced ☐ Single
☐ Co-Habiting ☐ Widowed

Child's Carers

☐ Both Parents ☐ Mother Alone
☐ Father Alone ☐ Other Relatives
☐ Adoptive Parents ☐ Foster Parents
☐ Children's Home
☐ Other(Please Specify):

Does the child have regular contact with Father? ☐ No ☐ Yes (How Frequent): ____________

Does the child have regular contact with Mother? ☐ No ☐ Yes (How Frequent): ____________

In the case of separated parent(s) – What kind of Custody Order is in place?

☐ Joint Custody ☐ Mother Alone ☐ Father Alone

In the case of Joint Custody, we require the contact details of the other parent/guardian

Name	
Address	

Telephone No: ____________________ Mobile No: ____________________

I am aware of the contents of this referral and agree to the release of all relevant reports to Linn Dara CAMHS. I/We agree for my/our child/ward to attend CAMHS for assessment.

Signature: ____________________ ____________________

	Mother/Guardian	Father/Guardian
Address:		
Phone:		
Date:		

Referral Received Stamp	Discussed at Team Meeting Date: Outcome: Priority:	Team Members: To be Seen within Outcome Letter Sent (referrer / parent)