CAMHS In-Patient Referral Form

Important note to referring Consultant/GP/Clinician: 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.

To be Completed by Referring Consultant

Name of Child:	**D.O.B:**
Address:	**Parents/Carer Contact No:**
Gender: **Religion:**	**Nationality:** **Country of Birth:** **First Language:**
Any Known Allegies: **Any Known Drug Allergies:**	**Any Special Needs Requirements:**

Details of Referring Consultant

CAMHS Consultant:	**Address:**
Contact No:	**Fax No:**
E-mail Address:	**Date of Referral:**