****

 **ALL** sections must be completed **Private & Confidential**

|  |
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| * Determining the ‘seriousness’ of a child or young person’s mental health, its severity, complexity and risk is always a clinical judgement. Every case referred will be assessed on a case by case basis. The final decision regarding admission rests with the inpatient Consultant Psychiatrist who assumes clinical responsibility for the child/young person once they have been admitted.
* Failure to provide requested information may result in a delay in triaging the referral and/or offering an access assessment.
* Please attach any other clinical reports.
* The referring Consultant Psychiatrist must ensure that they are contactable by phone to discuss the referral.
* When a referring Consultant considers that an order under Section 25 of the Mental Health Act (2001) may be required or where a child is under a Care Order (Child Care Act, 1991), contact must be made with the relevant inpatient Consultant Psychiatrist in advance. It is the responsibility of the referring Consultant Psychiatrist to ensure that a bed is available prior to going to court.
 |

**Referrals are accepted from Consultant Psychiatrists only.**

**Forms must be signed by the referring Consultant Psychiatrist.**

**Referral form sent to the following Inpatient Units:** Date form completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Yes, pleasex or ✓** | **Name of Unit** | **Address/Primary Catchment** | **Contact Details** |
| 🞎 | **Eist Linn CAMHSApproved Centre** | Eist Linn Child & Adolescent Mental Health Inpatient Unit, Bessbourough, Blackrock, Co Cork.**Primary catchment area; CHO 4 & 5** | Tel: 021 452 1100 Fax: 021 452 1164 |
| 🞎 | **Linn Dara CAMHSApproved Centre** | Linn Dara Child & Adolescent Mental Health Inpatient Unit, Cherry Orchard Campus, Ballyfermot, Dublin 10.**Primary catchment area; CHO 6, 7 & 8 [partial](Laois/Offaly/Longford/Westmeath)** | Tel: 076 695 6500Fax: 076 695 6636 E-mail: ac.linndaracamhs@hse.ie |
| 🞎 | **Galway CAMHSApproved Centre** | Galway CAMHS Approved Centre,Merlin Park University Hospital, Dublin Road, Galway.**Primary catchment area; CHO 1 [partial], 2 & 3,(Sligo/Leitrim/Donegal)** | Tel: 091 731 401Fax: 091 731 456E-mail: ac.galwaycamhsinpatient@hse.ie |
| 🞎 | **St Joseph’s Adolescent UnitApproved Centre** | St Joseph’s Adolescent Inpatient Unit, St Vincent’s Hospital Convent Avenue, Richmond Road, Fairview, Dublin 3.**Primary catchment area; CHO 1 [partial], 8 [partial], 9,(Cavan/Monaghan/Louth/Meath)** | Tel: 01 884 2460Fax: 01 884 2461 |
| 🞎 | Any other unit (e.g. private/abroad) | Details: |

**NB: All Emergency referrals must be accompanied by a telephone call to the inpatient clinical team**

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| **Please specify the level of concern for this young person based on your mental health assessment (Place x or ✓)** |
| **🞎 Emergency 🞎 Urgent 🞎 Routine** |
| **Emergency:** Involves cases where there is a clear and imminent risk to the young person’s safety due to their mental state.**Urgent:** Where there is a clear and present level of acute symptoms and where there is a strong likelihood of considerable deterioration in mental state if left untreated.**Routine:** Where there are clear and present levels of acute mental ill health symptoms which have been ongoing and can be managed in the short-term by the child/young person’s support network (i.e. Family, Community CAMHS). (HSE SOP, 2015) |
| **CAMHS office use** | Date and Time Received:  | Initials: |
| **Child/Young Person Details:** |
| **Name:**  | **Date of Birth:**  | **Age:** | **Gender:**  |
| **Preferred Name:**  | **Preferred Pronouns:**  |
| **Current Address:** | **Nationality:**  | **Ethnicity:**  |
| **Religion:**  | **Most spoken Language:**  |
| **Any known Allergies/Drug Allergies:**  | **Special consideration for communications:**  |
| **Any particular needs/requirements:**  |

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| **Person with Parental Responsibility: (if more than 2 parents please document in Family Composition)** |
| **Name of Parent 1:**  | **Name of Parent 2:**  |
| **Level of Contact with Child/YP:**  | **Level of contact with Child/YP:**  |
| **Address:**  | **Address (If different):**  |
| **Contact Numbers (Home, Mobile & Work):**  | **Contact Numbers (Home, Mobile & Work):**  |
| **Occupation:**  | **Occupation:**  |
| **Ethnicity:**  | **Gender:**  | **Ethnicity:**  | **Gender:**  |
| **Relationship to Child/YP:**  | **Relationship to Child/YP:**  |
| **Does the Child/Young Person reside with this parent?****YES 🞎 NO 🞎** | **Does the Child/Young Person reside with this parent?****YES 🞎 NO 🞎** |
| **Status of Parental Relationship (if applicable)**

|  |  |  |
| --- | --- | --- |
| **Please Tick ✓** | **YES** | **NO** |
| Married  |  |  |
| Divorced / Separated  |  |  |
| Cohabitating  |  |  |
| Single Parent  |  |  |
| Widowed  |  |  |
| No Contact |  |  |

 | **Who has Parental Responsibility of the Child/YP (Detail any court order)?**  |
| **Is the Child/YP subject to a Care Order?** **YES: 🞎 NO: 🞎** | **Type:****Voluntary** **Interim** **Care (Full Care Order)** | **🞎****🞎****🞎** |
| **Are TUSLA currently involved with the family? YES 🞎 *(Provide details on Page 12)*  NO 🞎** |

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| **Other Relevant Family Members (if known):** |
| **Name:** | **Relationship:** | **Age (If known):** | **Gender:** |
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| **Loco Parentis Details (if applicable):** |
| **Name:** | **Contact Number:** | **Address:** | **Relationship to C/YP?** |
|  |  |  |  |

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| --- |
| **Family Composition / Situation / Needs (i.e. Interpreter etc.) / Genogram:** |
| **Details:**  |
|  |

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| --- |
| **Primary Care Contact / General Practitioner:** |
| **GP Name:** | **GP Practice Name & Address:** | **Contact Number:** |
|  |  |  |
| **Access Assessment / Admission Discussion:** |
| **Please x or ✓** | **Yes** | **No** | **Unknown** |
| Is the child or young person agreeable to a potential access assessment? |  |  |  |
| Is the child or young person agreeable to a potential admission?  |  |  |  |
| Are both parents/Loco Parentis consenting to a potential access assessment? |  |  |  |
| Are both parents/Loco Parentis consenting to a potential admission? |  |  |  |
| Parent 1 Consent – Discuss: | Parent 2 Consent – Discuss: |

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| **Referrer (Consultant Psychiatrist) Details: (Must be contactable by telephone to discuss referral)** |
| **Name:** |  |
| **Team Name:** |  |
| **Address:** |  |
| **Contact mobile number(s):** |  |
| **Email Address:** |  |

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| **CAMHS Keyworker Details:** |
| **Name:** |  |
| **Team Name:** |  |
| **Address:** |  |
| **Contact mobile number(s):** |  |
| **Email Address:** |  |

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| **Other Important CAMHS Contacts:** **(Please include all professionals and contacts that should be involved in the child/young person’s care / discharge planning)** |
| **Name:** |  |
| **Profession:** |  |
| **Address:** |  |
| **Contact number: (Please include mobile number)** |  |
| **Email Address:** |  |

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| **Health Insurance Cover:** |
| **Please x or ✓** | **Yes** | **No** | **Unknown** |
| Private/Group Insurance  |  |  |  |
| Medical Card  |  |  |  |
| Details/Comments: |

|  |
| --- |
| **School/Education/Employment:** **(Please include School Reports)** |
| **Name of School/Education/Employment:** |  |
| **Address/Contact Details:** |  |
| **Details: (Level of functioning/year /any additional requirements in School [NEPS/Resource]/SNA required etc.)** |
| **Goal of Referral / Reason for Access Assessment: (Discuss rationale for level of urgency)** |
|  |

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| **Child / Young Person’s current Mental State:** |
| **Current Presentation: (include duration, frequency and severity of triggers, maintaining factors, coping mechanisms, current resources)** |
|  |
| **Appearance and behaviour:** |
|  |
| **Speech: (rate, intonation; volume; pitch; use of language; disorders of speech)** |
|  |
| **Mood and Affect: (subjective & objective)** |
|  |
| **Thought processes and content: (Formal thought disorder; delusions; preoccupations; obsessions; self-image)** |
|  |
| **Perceptions: (Hallucinations; derealisation/dissociation, Pseudo-hallucinations)** |
|  |
| **Cognitions: (Orientation to time; place; person; age; attention; concentration)** |
|  |
| **Insight: (Understanding of difficulties and motivation for change /Judgement)** |
|  |
| **Outcome measures: (HoNOSCA/CGAS/SDQ etc.)**  |
|  |

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| **Child/Young Person’s views and expectations/aim for access assessment/admission:** |
|  |

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| **Parent’s/Carer’s views and expectations/aim for access assessment/admission:** |
|  |
| **History of presenting complaint(s)** (To include details of onset, duration, severity, ameliorating and exacerbating factors, chronology of symptoms) |
|  |

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| **Psychiatric History:** (to include diagnoses, details of previous episodes of illness, services attended, inpatient admissions, any history of trauma) |
|  |

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| **Medication:** Please provide details of current medication including dosage and/or details of medications previously prescribed and rationale for why they might have been discontinued |
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| **Therapeutic Interventions:** Please provide details on all therapeutic interventions employed for child/young person and family. What works well? What has not worked to date?  |
|  |

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| **Child/Young Person’s Medical-Physical Health History: (Please include all/any reports available)** |
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| --- | --- | --- | --- |
| **Physical Intervention (Please X or ✓)** | **Yes (Attach reports)** | **No** | **Date** |
| GP/Consultant Physician assessment  |  |  |  |
| Blood Test(s) |  |  |  |
| ECG  |  |  |  |
| EEG |  |  |  |
| MRI |  |  |  |
| CT |  |  |  |
| Neurological Assessment  |  |  |  |

 |
| **Details of Child/Young Person’s Medical – Physical Health History & Interventions:**  |
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| **Relevant Family Medical / Psychiatric History: Please include engagement with services and any safeguarding issues:** |
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| **Developmental History:** |
| **Is there a neurodevelopmental disorder/history of difficulties? (e.g. ASD/Other)** | **YES 🞎 NO 🞎** |
| **Details: (History of Service Involvement - Include who undertook the assessment and results)**  |
|  |
| **Difficulties during pregnancy/birth?** |
|  |
| **Key developmental milestones/Any Trauma History?: (Please detail)** |
|  |

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| **Eating Disorder Specific Information:**  **(Please see Appendix for MaRSiPAN)** |
| **Diagnosis:** |  |
| **Date of Diagnosis:**  |  |
| **Child/Young Person’s understanding of the Eating Disorder?** ***Please specify if the young person is in agreement with the Eating Disorder diagnosis*** |  |
| **Families’ understanding of the Eating Disorder?** ***Please specify if the family is in agreement with the Eating Disorder diagnosis*** |  |
| **Adapted MaRSiPAN Risk Assessment Framework (Guides Clinical/Physical State of the Child/Young Person) Appendix 1** |
| **Risk Indicator**  | **Result/Details** | **Risk Category** |
| **BMI & Weight** |  |  |
| **Heart rateBlood Pressure** |  |  |
| **Hypovolaemia**  |  |  |
| **ECG** |  |  |
| **Hydration Status** |  |  |
| **Temperature**  |  |  |
| **Biochemistry**  |  |  |
| **Behaviours** |  |  |
| **Engagement**  |  |  |
| **Activity & Exercise**  |  |  |
| **Self-HarmSuicidality**  |  |  |
| **Other Mental Health Diagnosis**  |  |  |
| **Muscular – SUSS Test Stand – Squat**  |  |  |
| **Muscular – SUSS Test Sit – Up**  |  |  |
| **Other** |  |  |
| **Most recent weight:** |  | **Date weight recorded:** |  |
| **Most recent height (cm)** |  | **Date height recorded:** |  |
| **Most recent BMI** |  | **% Median BMI**  |  |
| **Weight/Height history and date record: (Attach records)**  |
|  |
| **Dietary intake over the previous two weeks: (Food diary can be attached)** |
|  |
| **Please specify interventions to rule out an organic cause:** | **Most recent bloods/date:Please specify LFT’s, FBC, U&E, Mg, PO4 & K** |
|  |  |
| **Vital Signs Sitting: (Pulse/BP/SpO2/Temp)** | **Vital Signs Standing: (Pulse/BP)** |
|  |  |
| **Compensatory behaviours:** | **Specify frequency:** |
| Excess exercise  |  |
| Binging  |  |
| Self-Induced Vomiting  |  |
| Laxative misuse  |  |
| Other |  |
| **Interventions to date:**  | **Details:** |
| Individual Work  |  |
| Family Based Treatment |  |
| Systemic Family Therapy  |  |
| Dietitian  |  |
| CBT (CBT-E) |  |
| Other |  |
| **Name & Details of other Agencies Involved:**(e.g. Primary Care Psychology, NEPS, Social Work, TUSLA, JLO, SLT. Include reports if available) | **Contact Details**  |
|  |  |
|  |  |
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**NB** – *Please provide available reports from other agencies*

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| **Drug / Alcohol:** |
| **Drugs: Past & Current use (include amount; frequency; motivation to use/change; effects)** |
|  |
| **Alcohol: Past & Current use (include amount; frequency; motivation to use/change; effects)** |
|  |

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| **Forensic History:** |
| **Forensic History: (Include involvement with diversion programmes / JLO etc.)** |
|  |
| **Criminal Charges:** |
|  |
| **Court Orders:** |
|  |
| **Court Dates:** |
|  |

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| **Relevant Social Circumstances: (Family dynamics, position of child in the family, precipitating/perpetuating/ protective factors; bullying; abuse history, hobbies/skills, strengths)**  |
|  |

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| **Risk Indicator Checklist (Please complete and provide additional information/explanation in the space provided)** |
| **Please ✓ risk indicators as appropriate**  | **Yes** | **No** | **Unknown** |
| Does the child/young person have a history of suicide attempts?  |  |  |  |
| Is the child/young person experiencing suicidal ideation?  |  |  |  |
| Is there a family history of suicide?  |  |  |  |
| Within the child/young person’s social network has there been instances of suicide or suicide attempts?  |  |  |  |
| Has/Is the child/young person currently experiencing an event which may be perceived as traumatic (e.g. Bullying, Physical/Sexual Abuse, Diagnosis of a Physical/Mental Illness?) |  |  |  |
| Does the child/young person engage in self-harming behaviours? |  |  |  |
| Has the child/young person experienced a significant loss either recently or in the past?  |  |  |  |
| Has the child/young person exhibited or is the child/young person exhibiting signs of inappropriate sexual behaviour?  |  |  |  |
| Has the child/young person in the past or currently presenting with behavioural difficulties?  |  |  |  |
| Has the child/young person a history of absconding/leaving without informing adults?  |  |  |  |
| Is the child/young person compliant with current care plan? |  |  |  |
| Does the child/young person have a history of self-neglect?  |  |  |  |
| Does the child/young person have a history of an eating disorder body image difficulties?  |  |  |  |
| Does the child/young person have low self-esteem?  |  |  |  |
| Does the child/young person have difficulty communicating their needs?  |  |  |  |
| Are there significant financial constraints that may affect the child/young person’s ability to self-care?  |  |  |  |
| Child/young persons or family drug/alcohol misuse-dependence?  |  |  |  |
| Does the child/young person have a history of violence or aggression towards adults/children/peers/animals?  |  |  |  |
| Has the child/young person ever made specific threats to harm others? |  |  |  |
| Does the child/young person often talk about death, killing or weapons?  |  |  |  |
| Do TV shows/Movies/Games of a violent nature fascinate the child/young person?  |  |  |  |
| Does the child/young person have access to, or carry weapons? |  |  |  |
| Is the child/young person experiencing thought/perceptual disturbance that consists of violence or harm?  |  |  |  |
| **Please provide details of all YES risks and any other risk issues:** |
|  |
| **List Protective Factors (Example: Resilience, Support Networks, Interests, Activities, Community Involvement, Functioning/IQ)** |
|  |
| **Any other relevant information** |
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| **Summary of Referral** |
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| **Summary of Clinical Impression at the time of referral:** |
| **ICD 11 Diagnosis:**  |
| **Axis 1** (Clinical Psychiatric Syndromes) | 1.2.3. | **Axis 4**(Medical diagnosis) |  |
| **Axis 2** (Specific developmental disorder e.g. autism)  |  | **Axis 5** (Psychosocial adversity) |  |
| **Axis 3** (Intellectual)  |  | **Axis 6**(Level of functioning)  |  |

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| **Please indicate the time and date that the Consultant Psychiatrist last reviewed the Child/YP** |
| **Date:** |  | **Time:** |  |

**\*Any child / young person referred must be seen by the referring Consultant Psychiatrist within the previous 48 hours**

*In the event that this referral for an access assessment results in an accepted admission and the identified child/young person is admitted to an Approved Centre, I the Consultant Psychiatrist will accept back the care and treatment of this child/young person upon their discharge from the Approved Centre.*

*In the case of Adult/Liaison/Private Consultant Psychiatrists’, I have discussed and agreed with the relevant CAMHS community service (Name of CAMHS Consultant Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) that the care and treatment of this child/young person upon their discharge from the Approved Centre will revert to the named CAMHS service/Consultant Psychiatrist.*

|  |  |
| --- | --- |
| **Consultant Psychiatrist** **Making the Referral Name:** |  |
| **Signature: (Must be electronic signature or hand signed)** |  |
| **Date:** |  |

**Appendix 1 – Adapted MaRSiPAN Risk Assessment Framework**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MaRSiPANRisk AssessmentFramework(2012 & 2015) | **RED****High Risk** | **AMBER****Alert to High Concern** | **GREEN****Moderate Risk** | **BLUE****Low Risk** |
| **BMI &** **Weight** | <70%percentage median BMI | 70-80%percentage median BMI | 80-85%percentage median BMI | >85%percentage median BMI |
| Recent loss of weight of ≥ 1 kg a week x 2 weeks | 500 – 999 grams a week x 2 weeks | Up to 500 grams a week x 2 weeks | No weight loss in past 2 weeks |
| **Heart rate****Blood Pressurea** | HR (awake) <40 bpmaIrregular heart rhythm (excluding sinus arrhythmia)Recurrent SyncopeMarked Orthostatic changes in systolic BP ≥ 20 mmHg or increase in HR of > 30 bpm | HR (awake) 40 – 50 bpmOccasional SyncopeModerate Orthostatic changes in systolic BP of 15mmHg or more or fall in diastolic BP of 10mmHg or more within 3 minutes of standing or increase in HR of up to 30 bpm | HR (awake)50 – 60 bpmPre-Syncope symptomsNormal Orthostatic changes | HR (awake)>60 bpmNormal BP for ageNormal Orthostatic changesNormal Heart Rhythm |
| **Hypovolaemia**  | Tachycardia or inappropriate normal HR for degree of underweightHypotension and prolonged capillary refill time |  |  |  |
| **ECG** | <15yrs QTc >460 msF >15yrs QTc >460 msM >15yrs QTc >450 ms***And evidence of*** –bradyarrhythmia or tachyarrhythmia (excludes sinus brady / sinus arrhythmia)ECG evidence of biochemical abnormality | <15yrs QTc >460 msF >15yrs QTc >460 msM >15yrs QTc >450 ms | <15yrs QTc 440-460msF >15yrs QTc 450-460msM >15yrs QTc 430-450ms***And*** taking medication known to prolong QTc interval, family history of prolonged QTc or sensorineural deafness | <15yrs QTc <440 msF >15yrs QTc <450 msM >15yrs QTc <430 ms |
| **Hydration Status** | Complete Refusal / Minimal Fluid Severe Dehydration (>10%) reduced urine output, dry mouth, decreased skin turgor, sunken eyes, tachypnoea, tachycardia. | Severe fluid restriction /Moderate dehydration (5-10%) decreased urine output, dry mouth, normal skin turgor, some tachypnoea, some tachycardiab. Peripheral oedema. | Fluid restriction / Mild dehydration (<5%): may have dry mouth or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance | Not clinically dehydrated |
| **Temperature**  | <35.5°C tympanic or35.0°C axillary | <36°C |  |  |
| **Biochemistry**  | ↓K,↓PO4,↓Na,↓Ca,↓AL,↓glucose | ↓K, ↓PO4, ↓Na, ↓Ca |  |
| **Behaviours** | Acute food refusal or estimated calorie intake 400–600kcal per day | Severe restriction (≤50% of required intake)Vomiting / Purging laxatives | Moderate restrictionBingeing |  |
| **Engagement**  | Violent when parents try to limit behaviour or encourage food/fluid intakeParental violence in relation to feeding (striking, force-feeding) | Poor insight into eating difficulties, lacks motivation to tackle eating difficulties, resistance to changes required for weight gainParents unable to implement meal-plan advice | Some insight into eating problems, some motivation to tackle eating problems, ambivalent towards changes required to gain weight but not actively resisting | Some insight into eating problems, motivated to tackle eating problems, ambivalence towards changes required to gain weight not apparent in behaviours |
| **Activity & Exercise**  | High levels of uncontrolled exercise in the context of malnutrition (>2hr / day) | Moderate levels of uncontrolled exercise in the context of malnutrition(>1hr / day) | Mild levels of uncontrolled exercise in the context of malnutrition (<1hr / day) | No uncontrolled exercise |
| **Self-Harm** **Suicidality**  | Self –poisoningSuicidal ideals with moderate to high risk | Self-injury or similarSuicidal ideas with low risk |  |
| **Other Mental Health Diagnosis**  |  | Other major psychiatric co-diagnosis (e.g. OCD / Psychosis / Depression) |  |
| **SUSS Test** **Stand – Squat**  | Unable to get up at all from squatting (Score 0) | Unable to get up without using upper limbs (Score 1) | Unable to get up without noticeable difficulty (Score 2) | Gets up without any difficulty (Score 3) |
| **SUSS Test** **Sit – Up**  | Unable to sit up at all from lying flat (score 0) | Unable to sit up from lying flat without using upper limbs (Score 1) | Unable to sit up from lying flat without noticeable difficulty (Score 2) | Sits up from lying flat without any difficulty (Score 3) |
| **Other** | Confusion / Delirium / Acute pancreatitis / Gastric or Oesophageal Rupture | Mallory-Weiss Tear / Gastroesophageal reflux or Gastritis / Pressure Sores | Poor attention and concentration |  |

**a**. Inappropriately high HR for degree of underweight are at even higher risk (hypovolaemia). HR may be increased through the consumption purposefully of excess caffeine.

**b**. Or inappropriate normal heart rate in an underweight young person.