Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Child and Adolescent Mental Health Services

Child & Adolescent Mental Health Services – Inpatient Referral Form

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

- 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 in-patient 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: _____

YES, Please x or ✓	NAME OF UNIT	ADDRESS / PRIMARY CATCHMENT	CONTACT DETAILS
☐	**Eist Linn CAMHS Approved Centre**	Eist Linn Child & Adolescent Mental Health Inpatient Unit, Bessbourough, Blackrock, Co Cork. **Primary catchment area; CHO 4 & 5**	0214521100 – Telephone 0214521164 – Fax
☐	**Linn Dara CAMHS Approved 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)**	017956500 – Telephone 017956636 – Fax ac.linndaracamhs@hse.ie
☐	**Galway CAMHS Approved Centre**	Galway CAMHS Approved Centre, Merlin Park University Hospital, Dublin Road, Galway. **Primary catchment area; CHO 1 [partial], 2 & 3, (Sligo/Leitrim/Donegal)**	091731401 – Telephone 091731456 – Fax ac.galwaycamhsinpatient@hse.ie
☐	**St Joseph's Adolescent Unit Approved 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)**	018842460 – Telephone 018842461 – Fax
☐	Any other unit (e.g. Private / Abroad)	Details:	

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

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)*

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:			

CAMHS office use | Date & Time Received:	Initials:

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 9) NO ☐

Other Relevant Family Members (if known):

Name:	Relationship:	Age (If known):	Gender:

Loco Parentis Details (if applicable):

Name:	Contact Number:	Address:	Relationship to C/YP?

Family Composition / Situation / Needs (i.e. Interpreter etc.) / Genogram:

Details:

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:

Referrer (Consultant Psychiatrist) Details: **(Must be contactable by phone to discuss referral)**

Name:	Team Name:	Address:	Contact mobile number(s):
Email Address:			

CAMHS Keyworker Details:

Name:	Team Name:	Address:	Contact mobile number(s):
Email Address:			

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)

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)

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.)

Child / Young Person's views and expectations / aim for access assessment/admission:

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)

Psychiatric History:

(to include diagnoses, details of previous episodes of illness, services attended, inpatient admissions, any history of trauma)

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:

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?

Child / Young Person's Medical-Physical Health History:
(Please include all / any reports available)

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:

Relevant Family Medical / Psychiatric History:
Please include engagement with services and any safeguarding issues:

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)	

Eating Disorder Specific Information: (If not relevant please move to Page 9) (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 rate Blood Pressure		
Hypovolaemia		
ECG		
Hydration Status		
Temperature		
Biochemistry		
Behaviours		
Engagement		
Activity & Exercise		
Self-Harm Suicidality		
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**

NB – *Please provide available reports from other agencies*

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)

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

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

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

Summary of Referral

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)	

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

MaRSiPAN Risk Assessment Framework (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 Pressure[a]	HR (awake) <40 bpm[a] Irregular heart rhythm (excluding sinus arrhythmia) Recurrent Syncope Marked Orthostatic changes in systolic BP ≥ 20 mmHg or increase in HR of > 30 bpm	HR (awake) 40 – 50 bpm Occasional Syncope Moderate 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 bpm Pre-Syncope symptoms Normal Orthostatic changes	HR (awake) >60 bpm Normal BP for age Normal Orthostatic changes Normal Heart Rhythm
Hypovolaemia	Tachycardia or inappropriate normal HR for degree of underweight Hypotension and prolonged capillary refill time			
ECG	<15yrs QTc >460 ms F >15yrs QTc >460 ms M >15yrs QTc >450 ms ***And evidence of*** – bradyarrhythmia or tachyarrhythmia (excludes sinus brady / sinus arrhythmia) ECG evidence of biochemical abnormality	<15yrs QTc >460 ms F >15yrs QTc >460 ms M >15yrs QTc >450 ms	<15yrs QTc 440-460ms F >15yrs QTc 450-460ms M >15yrs QTc 430-450ms ***And*** taking medication known to prolong QTc interval, family history of prolonged QTc or sensorineural deafness	<15yrs QTc <440 ms F >15yrs QTc <450 ms M >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 tachycardia[b]. 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 or 35.0°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 restriction Bingeing	
Engagement	Violent when parents try to limit behaviour or encourage food/fluid intake Parental 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 gain Parents 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 –poisoning Suicidal ideals with moderate to high risk	Self-injury or similar Suicidal 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.