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**Request for Service**

**Wakefield Specialist CAMHS** see Children & Young people with severe, complex or persistent mental health difficulties.

**Wakefield CAMHS Primary Intervention Team** see Children & Young People with moderate mental health difficulties.

The Primary intervention team currently offer the following group work interventions:

* Anxiety and Distress tolerance skills
* Behavioural Activation for Low mood
* Self-Compassion and building Self-Confidence

Please refer to Wakefield CAMHS Request for Service Guidance document for further information, which can be found on our website **https://www.southwestyorkshire.nhs.uk/services/camhs-wakefield/**

Key Notes:

* It is helpful for us to have the highest quality of information from referring agencies in order for us to process your request for service. Please fill out all the fields in this form. Your Request for Service is likely to be returned to you if this form is incomplete or partly completed.
* Letters will no longer be accepted by SPA from November 2018; with the exception of requests for ASD assessment of young people aged 14-18 where the CAMHS specific ASD form is required. All requests for service must use this request for service form.
* If you have completed all fields but on reading the Request for Service we are unsure of the mental health need you will be contacted by a CAMHS SPA Clinician within 48 hours to request further information. If we can’t get in touch with you we will send a letter asking for specific additional information. If we don’t hear back from you within this time your request for service will be discharged and you will be notified.
* **If you believe that the young person is at imminent risk to themselves or there are significant concerns that the young person may act on a plan to take their life then they need to attend accident and emergency for triage.**
* **You must inform parent/carer of this risk and download and discuss the safety plan form the website.**
* **Within working hours contact the SPA for further advice and consultation if you are unsure or need further advice.**

**Please post to:** CAMHS SPA, Flemming Court, Castleford, WF10 5HW

**Ring:** 01977735865 *to discuss a request for service with the SPA team*.

**Email request for service:** [**swy-tr.wakefieldcamhs.referrals@nhs.net**](mailto:swy-tr.wakefieldcamhs.referrals@nhs.net)

(emailed Request for Services **must** be via secure email i.e. NHS.net, GCSX, pnn.police.uk)

[**www.southwestyorkshire.nhs.uk**](http://www.southwestyorkshire.nhs.uk)

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| **About the Young Person** | | | | | | |
| **Name:** |  | | | | | |
| **Also known as:** | | | |  | | |
| **Date of Birth:** | | | |  | | |
| **NHS Number:** | | | |  | | |
| **Male** | | | | **Female  Other** | | |
| **Ethnicity:** | | | |  | | |
| **School attending:** | | | |  | | |
| **First Language:** | | | |  | | |
| **Interpreter required:** | | | | | **Yes**  **No** | |
| **Pregnant or has child under 1 year of age?**  **:** | | | | | **Yes  No** | |
| **Home Address:** | | | | | | |
|  | | | | | | |
| **Postcode:** | |  | | | | |
| **Method of contact:**  **Post  Telephone  Mobile** | | | | | | |
| **Postal Address (if different):** | | | | | | |
|  | | | | | | |
| **Postcode:** | |  | | | | |
| **Young person Telephone:** | |  | | | | |
| **Mobile:** | |  | | | | |
| **Parent / Carers names and contact numbers:** | | | | | |  |
|  | | | | | |  |
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| If your request for service is to query an **eating disorder** Height, Weight & Blood Pressure needs taking at the GP Surgery and recording here with the date taken.  **Please state any previous height / weight / blood pressure recordings and date taken:**  We also suggest at the time of completing this form, you arrange a follow up appointment to review your measurements. | | | | | | |
| **GP Name:** | | |  | | | |
| **GP Address:** | | | | | | |
| **GP Post Code:**  **Is young person currently on any medication that would be useful for us to know about?** | | | | | | |

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| **About the Referrer** | | | | |
| **Name:** |  | | | |
| **Job Title:** |  | | | |
| **Agency:** |  | | | |
| **Address:** | | | | |
|  | | | | |
| **Postcode:** | |  | | |
| **Telephone:** | |  | | |
| **Email:** | |  | | |
| **Signature:**  **(if not sent by email)** | |  | | |
| **Date of Request for Service:** | | |  | |
| **Date child / young person last seen by referrer:** | | | |  |
| **Is an** **Early Help Assessment in place?**  **Yes  No  Unknown**  **If so please attach latest copy and name of lead professional:** | | | | |
| **Is an** **Education & Health Care Plan (EHCP) in place?**  **Yes  No  Unknown If so please attach latest copy and name of lead professional:** | | | | |
| **Is a Child In Need plan in place**  **Yes  No  Unknown**  **If so please attach latest copy and name of lead worker:** | | | | |
| **Is there a Child Protection Plan?**  **Yes  No  Unknown If so please attach latest copy and name of lead worker:** | | | | |
| **Past CAMHS involvement:**  **Yes  No  Unknown** | | | | |
| **Who holds parental responsibility for care?**    **Is the young person in the care of the Local Authority?  Yes  No**  **If yes, please give name of Local Authority responsible for providing care:** | | | | |
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| **This page must be completed for the request for service to be considered by CAMHS. This is to ensure our policy around confidentiality and information sharing is adhered to. This also allows for more timely and thorough assessment of Request for Service information.** | | |
| **Has the young person consented to this Request for Service?** | **Yes** | **No** |
| **Has the parent/carer consented to this Request for Service?** | **Yes** | **No** |
| **If the young person is under 16 and has been seen alone or without parent / carers knowledge of the Request for Service can you confirm that you have assessed that they are Gillick Competent / or if 16-17 are they competent under the mental health act? (see our website for further guidance)** | **Yes** | **No** |
| **Have you seen this young person within the last two weeks?** | **Yes** | **No** |
| **If consent has not been given and the young person has not been seen within the last two weeks then we are unable to accept this referral.** | | |
| **Does the young person or Parent / Carer give consent for Wakefield CAMHS to contact other services involved with their care (this would be to gather more information in**  **relation to the Request for Service) If there are any services you do not give consent for Wakefield CAMHS to contact please state below.** | **Yes** | **No** |
| **Is there a safeguarding concern?** | **Yes** | **No** |
| **If you have ticked yes to a safeguarding concern it is your duty to contact social care or relevant safeguarding agencies (see our website for further guidance)** | | | **Yes** | **No** |

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| **Other agencies involved e.g. Social Worker, Family Support, Occupational Therapist etc.**   |  |  |  |  | | --- | --- | --- | --- | | **Name** | **Contact Details** | **Nature of Involvement** | **Currently open or closed to that service?** | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **School / College Details**   |  |  |  | | --- | --- | --- | | **Name of school / college** | **Main Contact** | **Is the child / young person attending** | |  |  |  | |

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| **This page must be completed for the request for service to be considered by CAMHS. This is to ensure we can offer a meaningful and appropriate response to young people and families.** |
| **Concerns and aims :**  **Please specify what mental health difficulty you think the child/young person has in your opinion and how this impacts on their daily functioning? Please provide evidence to support this. (For further support regarding our criteria please refer to the Guidance for Request for Service form.) If you are still unsure you can call our SPA telephone line on 01977 735 865.**  (Consider: nature of problem, timescale, description of behaviours, consideration to appetite and sleep difficulties, social interaction, school attendance, self-harm etc.) |
| **What has been tried already, and what has worked well / not so well? Please note that if early intervention support has not been tried then we will sign post to services for support. Please consider involving the in-school ‘Future In Mind’ workers before making a Request for Service to CAMHS.** |
| **Has there been a Significant Life Event?**  (*Consider: Complex bereavement responses, witnessed domestic violence / been a victim of neglect / physical emotional abuse, Parental mental health, parental drug or alcohol use etc.)* |
| **What are the expectations / goals of the young person? What support do they think they need from CAMHS (including parent expectation)**  *(Goals identified i.e. I want to get strategies to manage my anxiety / depression etc.)* |
| **How is the child / young person’s sleep? Do they have any of the following difficulties - please describe and provide as much detail as possible** *(struggling to fall to sleep / settle, sleeping too much, sleeping through the day, night time waking’s, early morning waking, night terrors / nightmares, other)* |
| **How many hours on average does the child / young person sleep each night.** |

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| **Special Needs and Risk Factors** | |
| **Does the child/young person have:** | |
| **Learning disability:**  **Mild  Moderate  Severe  None** | **Poor mobility:**  **Mild  Moderate  Severe  None** |
| **Literacy problems:**  **Mild  Moderate  Severe  None** | **Sensory impairment:**  **Mild  Moderate  Severe  None** |
| **Other disability / special need / formal diagnosis (i.e. ASD/ADHD)** | |
| **Child Health issues:  Yes  No** | **Educational Breakdown:  Yes  No** |
| **Family Health issues:  Yes  No** | **Housing issues:  Yes  No** |
| **Parental agoraphobia:  Yes  No** | **Parental Separation:  Yes  No** |
| **Parenting Issues :  Yes  No** | **Risk of violence / Domestic Abuse:  Yes  No** |
| **Substance Misuse Issues:**  **Yes  No**  **Alcohol  Drugs** | **Youth Offending issues:  Yes  No**  **Please attach appropriate details (contact name, report, etc.)** |
| *Consider: If you have indicated there are safeguarding concerns, it is your responsibility to follow protocol and make appropriate referrals. Where you have become aware of risk, you hold responsibility for this information rather than CAMHS.)*  **If you have ticked yes to any of the above please give details:** | |
| **Other risk factor e.g. Self harm, CSE, Violent behaviour– Please specify and give details below:** | |

