Confidential Camden CAMHS Self-Referral Form

Referral to the Child, Young Adult and Family Services

Date of Referral	DD / MM / YYYY

Section 1: Patient Details					
Has the Family/young person agreed to this referral?				☐ Yes	☐ No
Who has given consent for this referral?					
Full Legal Name			**D.O.B**	DD / MM / YYYY	
Preferred name *(if different)*			**Sex assigned at Birth**	☐ Female	☐ Male
Address	POSTCODE:		**Patient Phone / Mobile**		
			Carer Phone / Mobile		
NHS Number			**Patient email**		
Interpreter Required?	☐ Yes	☐ No	**If required, what language**		
Does the patient have any other communication support needs?	☐ Yes	☐ No	**If yes, please give more information**		
Who does CYP live with?			**Is the referred CYP an ex-member of British armed forces or dependent on such a person?**	☐ No ☐ Don't Know ☐ Yes, ex-services member ☐ Yes, dependant of an ex-services member	
Ethnicity Code					

Ethnicity codes

(A) White British	(E) White and Black African	(J) Pakistani	(N) African
(B) White Irish	(F) White and Asian	(K) Bangladeshi	(P) Other Black background
(C) Other White background	(G) Other mixed background	(L) Other Asian background	(R) Chinese
(D) White and Black Caribbean	(H) Indian	(M) Caribbean	(S) Any other ethnicity group

Patients 18 and over			**Current accommodation** *Living alone/ with friends or family etc.*	
	Employment status			
	Marital status			
Who has Parental Responsibility?				

Name of Referrer	DOB:	Relationship to referred child:

Other Family Members:	DOB:	Relationship:	M/F

Name of school/nursery attended by referred child:	Contact at school/nursery (if you consent to this) :

Do school/nursery have any concerns about this child? *(If yes, please give details)*

Name of GP: GP contact no: Surgery:	Have you discussed your concerns with your GP? Yes ☐ No ☐ Do we have your permission to contact your GP? Yes ☐ No ☐
Language/s spoken at home:	**Do you require an interpreter?** Yes ☐ No ☐

WHY ARE YOU MAKING THIS REFERRAL? *(please let us know what your concerns are about the child/children and what you would like us to do to help)*

FAMILY HISTORY *(please let us know of any history you feel is relevant to this referral)*

Has your family ever had any involvement with Social Services? Yes ☐ No ☐	*(if yes, please give details and name of allocated social worker if applicable)*

OTHER SERVICES/PROFESSIONALS INVOLVED:
Has anyone in your family been seen at the Tavistock Clinic or another Child and Adolescent Mental Health Service?
Yes ☐ No ☐
(*Please provide name, address and contact numbers of all other agencies involved)*

Name: **Address:**	**Name:** **Address:**	**Name:** **Address:**

This form should be returned to:

Email: tpn-tr.CYAF-Intake@nhs.net

Post: Camden Joint Intake - Referrals
120 Belsize Lane
London, NW3 5BA