**Self referral form for Specialist CAMHS referral.**

**Parents / Carers must have parental responsibility to refer to CAMHS if the young person is under 16 years old**

|  |  |
| --- | --- |
| **Date of referral:** | **Referrer information:** |
| **Name of referrer:** **Who has legal Parental Responsibility?** **Address:** **Email address:** **Tel. number:****Routine YES** [ ] **Urgent YES** [ ] **(Please be aware of the Crisis Team number *0800 0516171*** |

|  |
| --- |
| **GP Address (inc postcode) and Telephone number** |

**Consent for Referral:**

|  |  |
| --- | --- |
| **If the young person is 16 or over consent MUST be obtained by them before you submit your referral.** | **YES** [ ]  **NO** [ ]  **(if no, why?)** |
| **Do you or the young person (if over 16) give consent for us to discuss care with other professionals (CAMHS, GP and Local Authority) on a need to know basis?** | **YES** [ ]  **NO** [ ]  |
| **Is the young person aware of the referral to CAMHS?** | **YES** [ ]  **NO** [ ]  **(if no, why?)** |

**\*Please be aware that your information may be discussed anonymously with the Local Authority Multi Agency Screening Team to help inform decision making\***

**Child/Young Person details:**

|  |  |
| --- | --- |
| **Full name of Young person:** |  |
| **Preferred name:** |  |
| **NHS Number (if Known):** |  |
| **Gender:** |  |
| **Date of Birth & Age:** |  |
| **Language Spoken:** |  |
| **Nationality** |  |
| **Ethnicity**  |  |
| **Religion:** |  |
| **Address including postcode:** |  |
| **Contact name & telephone number:**[ ]  **Parent/Carer Name: Number:** **OR**[ ]  **Young Person****(Please be aware that if the referral is for a young person aged between 16 -18 years old, then we will need a contact number to speak with them directly)** |
| **Email Address:** |  |
| **School/College/ attended:** |  |

**Parent/Carer/Sibling Details (if relevant):-**

|  |  |
| --- | --- |
| **Who does the child / Young Person live with? (name, DOB & relationship to child/YP)** |  |
| **Siblings under 16yrs living in the family home (Name, DOB & School):**  |  |

**Details about the difficulty/issue:-**

|  |
| --- |
| **What is the reason for the referral and how long have issues been apparent for?**  |
| **How often are these issues happening & how is it impacting on their daily functioning?** |
| **Risk****(Suicidal thoughts, intent or plans of suicide, self-harming behavior’s, aggression towards self or others, vulnerable, at risk of harm from others)** |
| **Resilience** **Protective factors (e.g supportive family relationships or friendships)**, **what has / has not worked (e.g. taking time out when feels anxiety rising, school supporting workload) what is going well, what strengths qualities does the child/young person/family have that help them cope** |
| **What do you and the young person hope the service can provide?**  |
| **Are there any other services supporting you/ the young person? What was helpful or not helpful?****ie: Healthy Child Team, COMPASS Phoenix, Early help Service or Voluntary Services, Education Services.**  |

**Additional Information:-**

|  |  |
| --- | --- |
| **Health issues, significant past medical history:**  |  |
| **Medication:** |  |
| **Allergies:** |  |
| **Language Difficulties (to assist with telephone assessment).****Interpreter Required:** | **YES** [ ]  **NO** [ ] **(if yes which language if known)** |
| **Learning Disability/Difficulties known?** | **YES** [ ]  **NO** [ ]  |
| **Child Protection Plan in place?** | **YES** [ ]  **NO** [ ] **: (If yes, please provide** **name and contact number of Social Worker below)** |
| **Child in Need Plan in place?** | **YES** [ ]  **NO** [ ] **:**  |

**Other professionals involved in care of child/ young person:-**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes / No** | **Name and address (if known)** | **Consent to contact**  | **Contact number** |
| **General Practitioner** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Social Worker** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Support in Education** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Early Help Service** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Healthy Child Practitioner** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Voluntary Services** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Youth Justice Service** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **PIPA Service** |  |  | **YES** [ ]  **NO** [ ]  |  |
| **Other** |  |  | **YES** [ ]  **NO** [ ]  |  |

*We would also suggest the following useful websites*

[www.recoverycollegeonline.co.uk](http://www.recoverycollegeonline.co.uk)

[www.thegoto.org.uk](http://www.thegoto.org.uk)

[www.youngminds.co.uk](http://www.youngminds.co.uk)

|  |  |
| --- | --- |
| Ref: NHS No: Date:  | The Specialist Child and Adolescent Mental Health Service**Single Point of Access Team NY CAMHS**Based at: North Moor HouseNorth Moor RoadNorthallertonDL6 2FG |
| **Private & Confidential** | Website: [www.tewv.nhs.uk](http://www.tewv.nhs.uk)**Single Point of Access Team Number:** **0300 013 4778****Useful Websites:** [www.recoverycollegeonline.co.uk](http://www.recoverycollegeonline.co.uk)[www.childline.org.uk](http://www.childline.org.uk)[www.youngminds.org.uk](http://www.youngminds.org.uk) |

 Dear Parent/Carer

 Further to your recent request for CAMHS to consider a neurodevelopment assessment (ADHD).

Please find attached the required screening forms which yourself and school will need to complete and return to CAMHS in the first instance.

**Please note it is your responsibility to complete the pack and ensure all sections are complete.**

There is also a section for your child to complete, possibly with support from yourself if this is required.

If you are having any issues completing this form please speak with your child’s school or give us a call.

These forms are intended to provide us with more information specific to neurodevelopmental concerns and to evidence the need for further assessment if appropriate.

If there is lack of evidence to support a neurodevelopmental assessment we may not progress further and you may be signposted to more appropriate support services.

**Please return via email to tewv.northyorkshirecamhsreferrals@nhs.net**

* Parent’s section complete
* School’s section complete
* Child’s section complete

**Please note a referral will not be opened until the form is returned fully completed.**

Yours sincerely

**On behalf of North Yorkshire CAMHS**

Neurodevelopmental Assessment Clinic - ADHD

The questionnaire should be filled in by the parent or guardian who spends the most time with the child/young person. However, both parents can fill it in together if they want.

Please invite a key professional who knows your child/young person well (such as the SENCO at their educational provision) to add their comments in sections 8, 9 and 10.

|  |
| --- |
| 1. **Child/young person’s Details**
 |
| Child/ Young Person’s first name/s: | Child/young person’s family name:  |
| Date of Birth:  | Is the child/young person (please circle) Male Female Other If other, please provide details of how they identify:   |
| Child/young person’s Address: Post Code:  | First Language spoken by this child/young person/family: Interpreter needed? Yes/No  |
| 1. **Your child’s family**
 |
| Name:*e.g. Joe Bloggs*Does anyone in the family have a history of:* Neurodevelopmental difference?

*e.g. ASC, ADHD, dyslexia** Mental ill health?
* Serious physical illness?

  | Relationship to child:*e.g. father*  |
| 1. **Information about the child/young person**
 |
| Before your child was born, were there any problems with the pregnancy? Was your child born within 2 weeks of the expected date?***If not, how long was the pregnancy in weeks? \_\_\_\_\_***Were there any difficulties during labour and delivery?Did your child have to spend any time in a special care baby unit or in intensive care? How much did your child weigh at birth?Did your child meet their developmental milestones? Yes No Unsure (please circle)Has your child suffered from any health problems? ***If yes, please give details (include, for example, epilepsy, head injury, hearing difficulties)***Have you noticed any loss of language or social skills at any age in your child?Does this child/young person have any known medical conditions or impairments? *e.g. learning disability, global delay, learning difficulty, ADHD, mental health diagnosis, physical condition****(please include any allergies)*** Is this child/young person currently on any medication? If so, please detail:   |
| 1. **Significant events**
 |
| Please tell us of any significant life events that have occurred in the familyIs your child/young person presenting with distressed behaviours?***If yes, please give details (****e.g. self-harm, hitting, biting, kicking)* |

|  |
| --- |
| 1. **Information about previous involvement with our service**
 |
| Has this child been referred for an ADHD assessment previously? (If yes, when)Has your child had an assessment for ADHD previously (If yes, give details of service/outcome)  |
| 1. **Involvement with other professionals**
 |
| **Please tell us about any additional support this child/young person has previously received from professionals** *e.g. Health Visitor, Paediatrics, Specialist Teaching Services*  |
| **Is the child/young person or family currently supported by Social Care or have been in the past?**Currently: Yes No Don’t Know ( please circle)Previously: Yes No Don’t Know ( please circle)**Name and contact details of social worker** (if applicable) |

|  |
| --- |
| 1. **What nursery / school /college does the child/young person attend?**
 |
| Name of School/Setting: Current year group:Name of person at the setting that is the best person for us to speak to:  | Address:  Telephone contact details of School/Setting: |

|  |
| --- |
| FOR EDUCATION1. **What are School/ College or other professionals main concerns at the moment?**
 |
|  |

|  |
| --- |
| FOR EDUCATION1. **Academic and learning** *Please indicate the best description*
 |
|  | Better than Peers | Similar to Peers | More difficulty than Peers | Significant Difficulties |
| Independence Skills(including e.g. toileting, telling the time) |  |  |  |  |
| Motor Skills(including e.g. dressing self, pen grip) |  |  |  |  |
| Attention, organisation and planning skills |  |  |  |  |
| Memory and learning skills |  |  |  |  |
| Numeracy – particularly sequencing, reasoning and calculation |  |  |  |  |
| What level of work is the child/young person currently completing:In literacyIn numeracy |  |
| Do you think the child/young person is underachieving for their ability? | YES NO (please circle) |
| Has the school sought support from the Learning Hub? | YES NO (please circle) |
| Does the child/young person have a My Support Plan or an Education Health Care Plan in place? | YES NO (please circle) |

|  |
| --- |
| FOR EDUCATION10. Graduated Response Evidence by professionals over two terms/6 months: **This must include areas of need we would typically associate with a possible Attention Deficit Hyperactivity Disorder (ADHD), including needs as related to attention, hyperactivity, and impulsivity.****Please tell us what are school/college/other professionals doing currently to support these needs? *(above and beyond what is typical support for a child of this age and stage of development)***  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Plan****Area of need identified**  | **Start date of support** | **Do****Strategies used and who does it** | **Review****Describe the impact this support has had on the need identified** |
|  |  |  |  |

|  |
| --- |
| **11. What are parents/carers main concerns at the moment** |
|  |
|  |

|  |
| --- |
| **12.Graduated Response Evidence at home over two terms/6 months for children out of school or where there is a significant difference in presentation at home and school:** **This must include areas of need we would typically associate with a possible Attention Deficit Hyperactivity Disorder (ADHD), including needs as related to attention, hyperactivity, and impulsivity.****Please tell us what you are doing currently over the past 6 months to support the identified needs you describe? (above and beyond what is typical support for a child of this stage of development)**  |
| **Area of need identified**  | **Describe current strategies being used at home to support your child associated with the need** |
|  |  |
| **13.Current strengths and difficulties**  | **This column to be completed by parents/ carers**  | **This column to be completed by a key professional involved e.g. SENCO**  |
| Is this child able to concentrate on activities they enjoy? How long would they typically be able to focus for? |  |  |
| Does this child typically enjoy activities/tasks that require focus and attention, and can they remain focussed until that task is complete? |  |  |
| How long would this child be able to concentrate on a typical academic task for? (e.g. homework)Would they give the task the required level of attention without making too many careless mistakes? Would this be different if it was something they were interested in? |  |  |
| Is this child easily distracted from activities by things going on around them or by noises coming from elsewhere?Would this be different if they were doing something they enjoyed (e.g. watching a favourite TV programme)? |  |  |
| How good is this child at organising themselves to complete a task? For example, does this child forget or lose their belongings or items they might need to complete their work?Is this child able to remember things they need for school, or do they need help packing their school bag because they forget or lose things they need? |  |  |
| Does this child appear to listen to you when you are speaking directly to them? Do they ever appear to be day-dreaming or not concentrating on what is being said or asked of them? |  |  |
| If you gave this child a few simple instructions (e.g. go and fetch your jumper and shoes) do you think they’d be able to follow these without getting distracted or forgetting what was asked of them? |  |  |
| Is this child able to sit still and quietly when they are e.g. reading a book, watching a programme, playing a game, or waiting their turn? |  |  |
| Can this child remain seated when it is expected? e.g. dinner time, in class, at the cinemaDo they require a lot of prompting? |  |  |
| Would you say that this child is very active most of the time? When aren’t they active? |  |  |
| Is this child chatty, do they talk a lot? Are they able to remain quiet when needed? |  |  |
| If this child was being asked a question (they knew the answer to) or being given instructions, would they be able to wait until the question or instructions were finished before answering or starting the task? |  |  |
| Is this child able to wait their turn in games or conversations? |  |  |

|  |  |  |
| --- | --- | --- |
| Does this child struggle to settle down?e.g. to sleep at night or after returning to the classroom from playtime/break |  |  |

|  |  |  |
| --- | --- | --- |
| **14. Emotional wellbeing** | **Parent/carer observations** | **Key professional observations** |
| Anxiety or worry |  |  |
| Phobias |  |  |
| Obsessive behaviours |  |  |
| Signs of frustration or anger |  |  |
| Self esteem |  |  |
| Low mood or withdrawn |  |  |
| Sleep/tiredness |  |  |
| Eating |  |  |
| Relationship difficulties |  |  |

**Strengths and Difficulties Questionnaire**

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

*Please click to check the box*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Not** **true** | **Somewhat true** | **Certainly true** |
| Considerate of other people's feelings |[ ] [ ] [ ]
| Restless, overactive, cannot stay still for long |[ ] [ ] [ ]
| Often complains of headaches, stomach-aches or sickness |[ ] [ ] [ ]
| Shares readily with other children (treats, toys, pencils etc.) |[ ] [ ] [ ]
| Often has temper tantrums or hot tempers |[ ] [ ] [ ]
| Rather solitary, tends to play alone |[ ] [ ] [ ]
| Generally obedient, usually does what adults request |[ ] [ ] [ ]
| Many worries, often seems worried |[ ] [ ] [ ]
| Helpful if someone is hurt, upset or feeling ill |[ ] [ ] [ ]
| Constantly fidgeting or squirming |[ ] [ ] [ ]
| Has at least one good friend |[ ] [ ] [ ]
| Often fights with other children or bullies them |[ ] [ ] [ ]
| Often unhappy, down-hearted or tearful |[ ] [ ] [ ]
| Generally liked by other children |[ ] [ ] [ ]
| Easily distracted, concentration wanders |[ ] [ ] [ ]
| Nervous or clingy in new situations, easily loses confidence |[ ] [ ] [ ]
| Kind to younger children |[ ] [ ] [ ]
| Often lies or cheats |[ ] [ ] [ ]
| Picked on or bullied by other children |[ ] [ ] [ ]
| Often volunteers to help others (parents, teachers, other children) |[ ] [ ] [ ]
| Thinks things out before acting |[ ] [ ] [ ]
| Steals from home, school or elsewhere |[ ] [ ] [ ]
| Gets on better with adults than with other children |[ ] [ ] [ ]
| Many fears, easily scared |[ ] [ ] [ ]
| Sees tasks through to the end, good attention span |[ ] [ ] [ ]

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

**No Yes – minor difficulties Yes – definite difficulties Yes – severe difficulties**

[ ]  [ ]  [ ]  [ ]

**If you have answered "Yes", please answer the following questions about these difficulties:**

How long have these difficulties been present?

 **Less than a month 1-5 months 6-12 months Over a year**

[ ]  [ ]  [ ]  [ ]

Do the difficulties upset or distress your child?

**Not at all Only a little Quite a lot A great deal**

 [ ]  [ ]  [ ]  [ ]

Do the difficulties interfere with your child's everyday life in the following areas?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Only a little** | **Quite a lot** | **A great deal** |
| Home life |[ ] [ ] [ ] [ ]
| Friendships |[ ] [ ] [ ] [ ]
| Classroom learning |[ ] [ ] [ ] [ ]
| Leisure activities |[ ] [ ] [ ] [ ]

Do the difficulties put a burden on you or the family as a whole?

**Not at all Only a little Quite a lot A great deal**

 [ ]  [ ]  [ ]  [ ]

**Children and young people’s views** are very important when considering how best to support them at home, in school, and out of school. They can be very good at giving advice.

Please take some time to complete the attached questionnaire with the child or young person.

You may need to adapt it for younger or less able children.

Please offer your child or young person time to think about the answers.

Please make a note of any changes the child or young person would like to make to questions so they better fit their experience.

|  |
| --- |
| My thoughts and experiences |
|  |

Your answers will help everyone who knows you better understand what you think about your life, please try to be as honest as you can. Try and answer all the questions.

Name: Today’s date:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Never | Rarely | Half-and-Half | Usually | Always |
| 1 | Do you spend time with your friends outside of school? |  |  |  |  |  |
| If so, how do you spend that time? |
| 2 | Do you find it easy to concentrate on activities you enjoy e.g. watching a programme on TV, gaming? |  |  |  |  |  |
| If not, what makes it difficult? |
| 3 | Do you find it easy to concentrate during lessons at school?  |  |  |  |  |  |
| If not, what makes it difficult? |
| 4 | Are you easily distracted by things happening around you? Or maybe your own thoughts? |  |  |  |  |  |
| If so, what sort of things distract you? |
| 5 | How often do you find yourself experiencing strong emotions? |  |  |  |  |  |
| Can you describe what makes you feel this way? |
| 6 | Do you tend to be honest and say what you think to people? |  |  |  |  |  |
| Can you explain why? |
| 7 | How often do you spend time talking to others? |  |  |  |  |  |
| What sorts of things do you talk about? |
| 8 | Do you forget things easily or find that you have lost important belongings? |  |  |  |  |  |
| If so, what sort of things do you forget or lose? |
|  |
| 9 | Do you get bored easily? |  |  |  |  |  |
|  |
| What are the signs that you are getting bored? |
| 10 | Are you good at waiting? |  |  |  |  |  |
| If not, what happens when you need to wait? |
| 11 | Do you find yourself moving around without meaning to or feel uncomfortable staying still? |  |  |  |  |  |
| If yes, what do you do? |
| 12 | Do you find some sensations such as noises, lights, smells or textures overwhelming? |  |  |  |  |  |

Thank you for answering the questions, they will really help with your assessment.