CENTRAL POINT REFERRAL FORM

CAMHS Central Point
Young People's Centre
10 College Gardens
Belfast
BT9 6BQ
TEL: 02895 040707
Referrals can be emailed to: camhscentralpoint@belfasttrust.hscni.net

Disposition of referral:	Urgent: ☐	Routine: ☐

If you wish to make an urgent referral, please contact the Central Point Team on 028 95 040365 to discuss prior to submitting the referral.

Patient/ client			
Name		Date of birth	
Address		Telephone **(essential)**	
		Home	
		School (year?)	
Postcode		Work	
Health and Care Number		Mobile	

Parent/ carer details:			
Name		Relationship to young person	
Address		Telephone	
Postcode		Mobile	
Legal Status		Child Protection Register	

Family Composition:			

Referral Agent:			
Name		Occupation	
Address		Telephone	
		Mobile	
Postcode		E- mail	

General Practitioner:			
Name		Telephone	
Address		Post Code	
		GP Cypher	

Other professionals involved			
Name		Occupation	
Address		Telephone	
		Postcode	

CHI No:	

Date of last attendance at GP or hospital?	

Current Medication:	

Known allergies:

Baseline Mental State prompts and include frequency and duration where appropriate: • Mood • Thoughts of life not worth living (TLNWL)- Any plan or intent? • Suicidal ideation (SI)- Any plan or intent? • Deliberate Self-Harm (DSH)- Frequency and to what extent? • Sleep, Appetite, Socialising, School attendance • Trauma Symptoms • Drug or alcohol misuse • Previous involvement with services **Where there are concerns re disordered eating or an eating disorder please provide the following:** • Baseline weight • Baseline height • Baseline bloods
Reason for Referral

Has the child/ young person been referred to Mental Health/ Psychological/ Social Services previously? **If Yes please give details.**

Is there any history of self- harm/ self injury? **If Yes please give details.**

Is there any history of threats or actual harm to others? **If Yes please give details.**

Is there any history of alcohol, drugs or solvent use? **If Yes please give details.**

Is there any history of mental health difficulties in the child/ young person's family? **If Yes please give details.**

Is the child/ young person aware of this referral being made?

Has the child/ young person been made aware of or given consent for an assessment and/ or treatment and for other professionals to be contacted prior to the initial assessment?

<u>Checklist:</u> **Ensure all sections have been fully and accurately completed.** **Attach any reports/ documents which may assist in the assessment process.** **Please ensure up-to –date contact details/phone numbers are included.**

Signed:	Date:

Office use only
Date ref received:
Date ref discussed:

Contact sent:
1st appt: