

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 040707 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:	
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Date of last attendance at GP or hospital?	
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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?

Checklist:

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: