

**REFERRAL FOR SUPPORT FROM COMMUNITY CAMHS (Healthy Young Minds Stockport)
INCORPORATING SECONDARY JIGSAW, AND
CHILDREN'S PRIMARY MENTAL HEALTH PRACTITIONERS.**

Child's First Name:
 Child's Surname:
 Gender: Male Female
 D.O.B.: Age:
 School: Year Group:
 Parents/Carers Name:
 Address:
 Tel No:
 GP Name + Practice Address:

Referring Agency:
 Named Contact:
 Address:
 Tel No: Fax No:
 E-mail:
 Community CAMHS Consultation completed. Yes No
 Name of person consulted with:
 Date of consultation:

Referred for:
 Secondary Jigsaw

OTHER AGENCIES INVOLVED	CURRENT INV (Tick)	PAST INV (Tick)	IS AGENCY AWARE OF REFERRAL?	CONTACT NAME & NUMBER
CAMHS				
Social Services				
Connexions				
Young Carers				
Sure Start				
Youthful Minds				
Youth Offending Team				
Making it back				
Educational Psychologist				
Education Welfare Officer				
Parent Partnership				
Sensory Impairment Services				
Speech and language therapy				
Other (specify)				

Has / is the young person accommodated by a Local Authority? YES NO Child's legal status

Has / is the young person on the Child Protection Register? YES NO If yes, please supply additional information.

Child/Young Person's Ethnicity (please tick below)

Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>	White British	<input type="checkbox"/>	White & Black Caribbean	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	White Irish	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>	Ethnic Group Not given	<input type="checkbox"/>
Any Other Black Background	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Any Other White Background	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>		
Any Other Asian Background	<input type="checkbox"/>			Any Other Mixed Background	<input type="checkbox"/>				

Is the Young Person an asylum seeker? If yes please provide details
 Yes No

Young Persons First Language:

Parent(s) First Language:

Is an interpreter or signer required? Yes No

Has this been arranged: Yes No

REASON FOR REFERRING THE YOUNG PERSON (please tick as appropriate)

Family relationship problem	<input type="checkbox"/>	Anxiety and fears	<input type="checkbox"/>
Psychosomatic disorder	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>
Eating Problem	<input type="checkbox"/>	Avoidance of school	<input type="checkbox"/>
Sadness/Depression	<input type="checkbox"/>	Stealing	<input type="checkbox"/>
Grief reaction/Bereavement	<input type="checkbox"/>	Recent change in behaviour	<input type="checkbox"/>
Autistic Spectrum Disorders	<input type="checkbox"/>	Self Harm	<input type="checkbox"/>
Drug Use/Abuse including Alcohol	<input type="checkbox"/>	Aggressive Behaviour	<input type="checkbox"/>
Social Relationship Problems	<input type="checkbox"/>	Bullying	<input type="checkbox"/>
Other – Please describe	<input type="checkbox"/>	Identity issues	<input type="checkbox"/>

REASON FOR REFERRAL

POSSIBLE CONTRIBUTING FACTORS (Please tick as appropriate)

Mental Health problems in family (please specify below)	<input type="checkbox"/>	Young Carer	<input type="checkbox"/>
Dependant Relative	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	Physical Disability	<input type="checkbox"/>
Child in need	<input type="checkbox"/>		

Additional information

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OUTLINE STRENGTHS OF:

1) YOUNG PERSON

2) FAMILY

3) ENVIRONMENT

4) MANAGEMENT OF SITUATION

Does the young person have a Statement of Special Education Need? Yes No

Has the young person had a fixed term or a permanent exclusion in the past 12 months? Yes No

To support this referral please attach, additional information, limited information may delay the process:

Educationally based referral

- Attendance record
- Recent School Report
- Copy of most recent IEP and Review Report
- SEN staged assessment or copy of EHC plan

Social Care based referral

- Initial Assessment Record
- Promoting positive mental health assessment
- Core Assessment
- AIM Assessment
- LAC Review Minutes
- CIN / Child Protection Minutes

Health based referral

- Medical Advice
- Mental Health Assessments
- Specialist referral letters

I / We agree with this referral being submitted to the Community CAMHS Operational Panel and that in accepting this referral, information will be shared between the agencies specified to ensure appropriate assessment is completed and workers identified. I / We reserve the right to change my/our decision, and will inform the referrer of this action immediately.

Signature Parent/Carer:

Date:

Please also print name:

Signature Young Person:

Date:

Please also print name:

Signature Of Referrer

Date:

Please return this form to:

Community CAMHS, Tree House, Stepping Hill Hospital, Poplar Grove, Stockport, SK2 7JE
 (Service also known as HYMS – Healthy Young Minds Stockport)

Secondary Jigsaw Service

The Jigsaw Service is an education mental health team which aims to work alongside mainstream secondary schools and detached services to improve the educational and emotional opportunities for those students experiencing mental health difficulties and to offer support to their families/carers. The team consists of a team coordinator, 2 mental health practitioners, 1 teacher, 1 family resource worker and 1 Dramatherapist. We are based at Secondary Jigsaw, Pendlebury Centre, Edgeley Road, Cheadle Heath, Stockport, SK3 0RJ. The team provides consultation sessions with schools to discuss referrals and to offer advice regarding making referrals. For more information contact the team on 0161 428 9305 Option 1. Or e-mail jigsaw@pendlebury.stockport.sch.uk