

REFERRALS TO SUTTON CHILD & ADOLESCENT MENTAL HEALTH SERVICES

Please send by secure email to SuttonCAMHSReferrals@swlstg-tr.nhs.uk

If you do not have access to either, please call 020 3513 3800 or Fax 020 3513 3993

Name of child:	DOB:
	NHS Number:
Address:	
Post code:	
Mobile Tel. No.:	Other Tel. No.:
LAC Yes / No	Disability: Yes / No

ETHNICITY

White British		Any other mixed background		Black/Black British Caribbean	
White Irish		Chinese		Black or Black British African	
Any other White		Asian or Asian British Indian		Any other Black groups	
Mixed: White/Black Caribbean		Asian or Asian British Bangladeshi		Any other ethnic group	
Mixed: White & Black African		Asian or Asian British Pakistani		Declined to state ethnicity	
Mixed: White & Asian		Any other Asian background			

REFERRER DETAILS

Name of Referrer:	Organisation:
Address:	
Telephone No.:	Email address:

MEDICAL DETAILS

Name of GP:	Practice Name:
Address:	
Telephone No.:	Email address:

School:	
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FAMILY MEMBERS

[illegible]

Presenting Problem:

Brief history of problem:

Impact of problem on the family

Other sources of stress for the family

OTHER PROFESSIONALS CURRENTLY INVOLVED	
PROFESSION	NAME AND ADDRESS

Please list any interventions that have already been attempted, by who, and attach any reports:

Have the family had contact with Child Mental Health Services in the past? Yes/No

If so, please give details

PARENT/GUARDIAN	
Are parents aware of this referral?	Yes/No
If no, please give reasons:	
What do parents/child expect from this referral?	
What do you as a referrer expect from this referral?	

Level of concern:		Please give reasons:
High		
Moderate		
Routine		

Signature of Referrer:	Date:
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In signing this form on behalf of the parent/guardian you are confirming that consent has been granted for South West London and St Georges Mental Health Trust - Sutton CAMHS to share the referral information as outlined in this document with other agencies.

Signature confirming that Parent/Guardian has consented:	Date:
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