NHS
Cornwall Partnership
NHS Foundation Trust

HEADSTART KERNOW

CORNWALL COUNCIL
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Referral form

Please complete fully - insufficient information may lead to the form being returned, resulting in a delay.

Bloom is offered as an early intervention service and a professionals meeting. Whilst it is a separate service it has close links to Cornwall CAMHS. This means that referrals not accepted to Bloom may be signposted to the Early Help Hub and/or other support services.

Referrals will only be accessed during office hours, on a weekly basis.

If you are concerned about a child or young person's welfare, please contact the Early Help Hub:

w. earlyhelphub@cornwall.gov.uk

t. 01872 322277 or MARU 0300 123 1116

Criteria met

Yes   No

- **Has the family identified who they would like to be the nominated professional?***

Name of nominated professional:

Phone/Email:

Yes   No

- **Does the referring school have a Designated Mental Health Lead?**
- **Has the referral been discussed with the School Mental Health Lead/Champion?**

Name of Mental Health Lead: **Date discussed:**

*For more information about the role of the nominated professional please refer to the handbook/information leaflets

Person referring

Name of referrer

Job title

Date of referral

Name of organisation

Telephone number

Email address

Child or young person being referred

First name(s)

Surname

Preferred name

Age   **Date of birth**

Male   Female   Gender identified as

Ethnicity

First language

Address

Postcode

Child or young person being referred

Who does the young person live with? Please tell us anything else important about the family.

Details of parent/carer

Full name

Relationship to child/young person

Parental responsibility?   **Lives with child/YP?**

(Yes)   (Yes)

Email address

Email address 2

Mobile phone number

Home/landline phone number

I am happy to receive information electronically

I am happy to receive voicemail messages

Name & Address of any other person with legal parental responsibility (if different)

Email address

Mobile phone number

Home/landline phone number

I am happy to receive information electronically

I am happy to receive voicemail messages

Consent

BLOOM work as a partnership in line with One Vision Statutory Plan in order to identify and provide the right support for every child and Young Person. This means that your referral will be screened by a CAMHS professional and signposted to the most appropriate service which may include CAMHS, CAMHS commissioned community based services, NHS services, services provided by Cornwall Council and/or the Voluntary Community Sector.

Ensure consent is obtained from the family for a Referral and for sensitive information to be shared with professionals in the CAMHS Access Team and those that form the BLOOM Panel. Please note anybody over 13 years, who is deemed competent, can give their own consent. This may be with or without parental consent.

*By ticking this box, you are confirming that the following verbal consent has been given: "I agree to this Request and to my information being shared with agencies that are part of the BLOOM response."

Yes

- **Are the Parent/Carer's aware of this referral?**

- **Is the young person aware of this referral?**

- **Has the parent/carer agreed to information being shared between agencies?**

- **Has the child/young person agreed to information being shared between agencies?***

Name of person giving consent

Signed   **Date**

Privacy Statement

GP details

NHS Number (if known)

Practice address

Name of GP

Telephone number

Vulnerable children (Please complete all sections)

Yes   No   Unknown

- **Is the child subject to a Child Protection Plan?**
- **Has the child been subject to a Child in Need Plan?**
- **Has the child been subject to a Child Protection Plan in the past?**
- **Is the child a "child in care" (eg fostered) by the Local Authority?**
- **Is the child subject to a Special Guardianship Arrangement?**
- **Does the child have an Education and Health Care Plan (EHCP)?**
- **Does a member of the immediate family work for the Armed Forces?**
- **Is the child under the Youth Offending Service (YOS)?**
- **Previously known to CAMHS?**
- **Previously known to MHST?**

Other professionals involved

Are you currently working with , or have you worked with any other agencies, people or organisations, including your school?

Special requirements (e.g. Interpreter, Wheelchair Access, etc. Please give details below)

Reason for referral

Please consider the following when compiling your referral:

- Appearance
- Communication
- Mood
- Appetite
- Sleep
- Self-worth and self-image
- Hopelessness
- Family history
- Social situation
- Risk/ Self Harm/ Suicide: are any indicators of risk present for self-neglect, self-harm, abuse or suicide?

Frequency, Intensity, Duration and Onset of difficulty

Concerns

What are you worried about?

What impacts are the difficulties having on family life, school work, friendships etc?

What is working well?

- Appearance
- Communication
- Mood
- Appetite
- Sleep
- Self-worth and self-image
- Hopelessness
- Family history
- Social situation
- Risk/ Self Harm/ Suicide: are any indicators of risk present for self-neglect, self-harm, abuse or suicide?

What do you think needs to happen?

Risk

- **Are there any risks in relation to this child or young person?**
  (e.g. risk of suicide/self-harm, to/from others)   Yes   No

- **If you are concerned about risk, is there a current safety plan in place?**   Yes   No

Please give details

Additional information

Is there any further information that you think we should know?
E.g. Any big family/life events or illnesses recently?

Next steps

Please send completed forms to: **cft.camhsreferrals@nhs.net**

If you have any questions or queries regarding the status of your referral,
please email or call us on 01208 834575 in the first instance.