**The Specialist Community Service for Learning Disability & Autism, CAMHS**Referral Form

Most autistic young people who are in need of Child and Adolescent Mental Health Services (CAMHS) will be seen by our Core teams. The Specialist Community Service for Learning Disability and Autism (SCS-LDA) supports children and young people with severe learning disabilities and autistic young people who have complex needs. The service is for young people and their families if there are significant issues with behaviour **at home** and/or concerns about mental health.

Please complete all sections: Information about the young person you are referring, information about the parent(s)/carer(s) of the young person, information about your referral, and submitting your referral.

Ensure all **mandatory sections** (in **bold** and marked with an **asterisk [\*]**) are completed. Referrals that do not have all the mandatory fields completed may be returned.

**Information about the young person you are referring**

|  |  |  |
| --- | --- | --- |
| **Full name \***  Click or tap here to enter text. | **Date of Birth \***  Click or tap here to enter text. | |
| **Gender \***  Click or tap here to enter text. | Ethnicity  Click or tap here to enter text. | |
| NHS number  Click or tap here to enter text. | | |
| **Address \***  Click or tap here to enter text. | | |
| Phone number *[if applicable]*  Click or tap here to enter text. | Email address *[if applicable]*  > | |
| **Name and address of school/place of education \*** | | |
| **Name and address of GP \***  Click or tap here to enter text. | | |
| Please give details of any relevant medical information  Click or tap here to enter text. | | |
| Name and contact details of social worker or early help worker [*if applicable*]  Click or tap here to enter text. | | |
| **Status *[please complete all boxes]* \*** | | | |
| Formal diagnosis *[select all that apply]*  Autism  Learning disability  Other  *Please state:* Click or tap here to enter text.  Does the young person have an EHCP?  Yes  No | | Does the young person have regular Child in Need (CIN) meetings?  Yes  No  Is the young person the subject of a child protection plan?  Yes  No | |

**Information about the parent(s)/carer(s) of the young person**

|  |  |
| --- | --- |
| **Full name(s) \***  Click or tap here to enter text. | **Relationship(s) to young person \*** |
| **Address(es) \***  Click or tap here to enter text. | |
| **Phone number(s) \*** | Email address(es)  As above |
| **Does the person/do the people named above have parental responsibility? \***  Yes  No  *If you have selected no, who does have parental responsibility?* Click or tap here to enter text. | |
| **Please confirm that the person/people with parental responsibility have consented to this referral. \* Please note that referrals submitted without this consent being sought will be rejected.**  Yes  No | |
| **Please confirm that the parent(s)/carer(s) consent to us discuss this referral with other professionals as necessary as part of our triage process. \***  Yes  No | |

**Information about your referral**

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| **Please describe why you are referring this young person to CAMHS and what you would like help with. \***  **Please note: the more details you provide about this young person's mental health and/or behaviour the easier it will be for us to process your referral. A lack of detail may result in delay.**  Click or tap here to enter text. |
| **Is there any danger of harm to the young person or others? If so, please describe \* If your referral contains information about risk, please call the duty desk at CAMHS. Please see the details at the end of this form.**  Click or tap here to enter text. |
| **How long have these difficulties been going on for? \***  Click or tap here to enter text. |
| **Please give details of anything that has been done so far to address these difficulties. How effective have these interventions been? \***  Click or tap here to enter text. |
| **How do you think we can help? \***  If you would like to refer for one of our group interventions, please select below and also confirm you have read the information below:  Riding the Rapids  If referring for groups [*please select to confirm*]:  Our groups are usually run on weekday mornings in varying locations across the city for approximately two hours per session. Group lengths vary between four to ten weeks. Please confirm the parent(s)/carer(s) would be able to attend in these circumstances  Please confirm that the parents/carers are aware that we do not have a crèche available at our groups |
| **Please provide names and contact details of other professionals who are or have been involved *[e.g., Community Paediatrician, SALT, GP, etc]* \*** |
| **Does the young person or do the parent(s)/carer(s) of the young person require an interpreter? \***  Yes  No  *If yes, please state language****:*** Click or tap here to enter text. |

**Submitting your referral**

|  |  |
| --- | --- |
| **You are [*please select one box*] \***  A parent or carer    A professional [*Please fill in details below*] | |
| **Professional’s full name \***  Click or tap here to enter text. | **Job title \*** |
| **Professional’s phone number \***  Click or tap here to enter text. | Professional’s email address  Click or tap here to enter text. |
| **Professional’s address \***  Click or tap here to enter text. | |
| **Type to print or sign your name \*** | |
| **Date of referral \*** | |

Please send **completed referrals** or **queries** to[**mft.scs-lda@nhs.net**](mailto:mft.scs-lda@nhs.net)

Please scan and attach any other **relevant reports** or **supporting documentation**

**If your referral contains information about risk, please call your local duty desk at CAMHS to discuss this:**

**North Manchester: 0161 203 3250  
Central Manchester: 0161 701 6880  
South Manchester: 0161 529 6062**