**Please complete all sections of the form to avoid any delays and send to:**

Sussex Partnership

**CAMHS, The Aldrington Centre, 35 New Church Road, Hove, BN3 4AG**
**Tel: 01273 718680 Fax 01273 738407**

# Referral form
## Child and Adolescent Mental Health Service

**Please complete this form using block capital letters only**

Child Forename: Child Surname: CAF No:

(Please attach CAF assessment and current action plan)

Gender: Male ( ) Female ( ) D.o.B.:

Address:

Post Code:

Is the Child Looked After? Yes / No

| | |
|---|---|
| Telephone Number: | Mobile Number: |
| Ethnicity: | Language spoken at home: |
| Interpreter/Special access needs required?: Yes/ No | Details: |
| Is referral child in care?: Yes/No | NHS No: |
| Parent/Carers Name: | |
| Addresses of Parent/Carers (if different): | |

Telephone Numbers (if different):

Key Family Members/Carers:

School Name:

Key Professional Contact:

Address:

Post Code:

Telephone Number:

GP Name: Telephone Number:

Address:

Has this referral been discussed with the family / young person: Yes ( ) No( )

Reason for referral (plus referrer's expectations):

Previous concerns, if any, and/or previous contact with CAMHS

Any additional information including other professionals/agencies currently or previously involved:

*Please continue on separate sheet if necessary*

Please describe any safety issues for the family/young people or the professional, (who may be lone working),
e.g. domestic violence, self harm/suicidal thoughts, parental mental health issues, safeguarding:

What are the family's expectations of why they are attending CAMHS / what they will receive?

Referrer Name: Referrer Title:

Contact Details including email address:

Date of Referral: Signature:

**Thank You**