Swindon Borough Council

NHS Oxford Health NHS Foundation Trust

TaMHS

Swindon Single Point of Access Referral Form

Targeted Mental Health Services (TAMHS) AND

Child and Adolescent Mental Health Services (CAMHS)

Name of child / young person:

Please indicate if you would like us to consider a specific service:

☐ TAMHS ☐ CAMHS ☐ Learning Disability CAMHS ☐ TEDS – The Eating Disorder Service (CAMHS)

Every weekday all referrals are jointly screened by a manager from TAMHS and CAMHS who will decide what they believe is the most appropriate action to take based on the information you have provided.

A first-line intervention should have taken place prior to a referral to TAMHS, e.g. school counselling, health visitor, school nurse, Parent support advisor.	**Interventions are provided to children & young people aged 0-18 and their families and carers, where the following difficulties are presented, with co-morbid mental health symptoms:** • Persistent difficulties in making and maintaining relationships with family & peers, including insecure attachments • Children & young people whose impaired mental wellbeing interferes with social & educational performance • Children & young people exhibiting symptoms of low mood, anxiety, emotional distress, including significant self-harm and phobias • Children & young people reacting to issues of bereavement, trauma & loss • Children & young people where there are concerns about a developing mental illness, e.g. eating disorder, distorted body image, compulsive & obsessive behaviour patterns, gender identity • Children & young people where their emotional & mental health is significantly impacting on their typical development
TAMHS offers time-limited interventions, to address emotional and mental health needs of young people at an early stage, with the aim of reducing long-term mental health problems.	
Services are provided for children & young people who have defined needs that are complex in range, depth and significance, where a first-line intervention or single service is unable to meet those needs.	
Information about the service provided in **Swindon by CAMHS** is available at **http://www.oxfordhealth.nhs.uk/children-and-young-people/south-west/**	

Email to: tamhs@swindon.gcsx.gov.uk
Post to: TaMHS, Saltway Centre, Pearl Road, Swindon, SN5 5TD
ONLY FROM SECURE EMAIL SLocalityIntegratedBST@swindon.gov.uk
All non-secure sites documents either posted to address above or email with Egress.

Section 1: Child / young person & family details

1(a) About the child / young person

Given name			Current educational setting name & address (*if not referrer*)	
Family name			Telephone or contact details	
Also known as			General Practitioner name & address (*if not referrer*)	
Date of birth				
Age			Telephone/ contact details	
Gender	☐ **Identifies as Male**	☐ **Identifies as Female**	NHS No:	
	☐ **Identifies as Other**	☐**Prefer not to say**		
Ethnicity	Choose an item. Other:		Child / young person aware of the referral?	☐ **Yes** ☐ **No**
First language			Child / young person consent for this referral?	☐ **Yes** ☐ **No** If no please state why – Click here to enter text.
Home address/ postcode				

Telephone/contact details	

1(b) About the parents / carers

Name	Relationship	Contact details	Parental Responsibility?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

Section 2: Identify needs & concerns (*please refer to TaMHS/CaMHS criteria*)

2(a) What is the evidence of previous help – what has been tried? What was the impact?

To prevent any delay in processing your referral, it is important that you attach evidence of any previous support i.e. attach Early Help record and Plan, TAC reviews, etc.

EHR & Plan

2(b) The referrer

What outcomes are you hoping to achieve from this referral?
Prompts: *tell us about how long, how serious, frequency. Why refer now? Impact on child's life and ability to function.*

2(c) Child / young person

What do you want to happen as a result of this referral?
Prompt: What changes does the child/young person want to happen as a result of this referral?

2(d) Parents / Carers

What do you want to happen as a result of this referral?
Prompt: What changes do parent / carer want?

Section 3: Other agencies involved

3(a) Please tick if working with / have worked with child / young person / family

☐ **Young Carers**	☐ **SBC Family Service**	☐ **Family Centres**	☐ **Nursery/Pre-school**
☐ **CAMHS/TaMHS**	☐ **YEW**	☐ **Health Visitor**	☐**School Nurse / LD Nurse**
☐ **Youth Offending Team**	☐ **Education Psychologist**	☐ **Physiotherapy**	☐ **U-turn**
☐ **Education Welfare Officer**	☐ **Social & Emotional Mental Health Support Team (S.E.M.H)**	☐ **Inclusion/Learning Support**	☐ **Parent Support Advisor**
☐ **SALT**	☐ **Occupational Therapy**	☐ **Paediatrician**	
☐ **School**	☐ **On Trak**		☐ **Other (please state)**

If an agency is currently working with the child / young person / family please provide the following details (Use 2nd sheet if necessary):

Start Date	Agency	Name & Role	Tel Contact Nos

Section 4: Referrer's details

Name	
Job Title	
Agency	
Address	
Postcode	
Contact details	
Signature	
Date of referral	

4(a) Has this form been copied to parents?

☐ **Yes** ☐ **No**

4(b) Has this form been copied to the young person?

☐ **Yes** ☐ **No**

Section 5: Consent *IMPORTANT: Please complete*

We would like your consent to contact any one of the agencies listed on the front sheet, and refer on, as appropriate.
We may also want to contact other agencies that know you, such as your school or GP, to help us provide a better service to you.
We will ensure that your personal information is kept confidential, unless there are specific concerns that require us to share your details. You will be told of this.

5(a) Please complete the attached Privacy Statement/ Consent form

5(b) If no consent, please state why:

To be completed by office personnel	
Person screening case	
Decision made	Date
Comments	

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Swindon
BOROUGH COUNCIL

Revised
24 August 2015

Children, Families and Community Health consent to share information

Child/Young Person's Name: Click here to enter text. D.O.B: Click here to enter a date.

Parent/Carer's Name: Click here to enter text.

From our work with you, we will hold information about you and your family on our electronic data base. For example demographic information such as; name, address, date of birth, ethnicity. We will also hold details of meetings you attend, assessments, plans and case information.

More detail is included in the privacy notice.

Your worker would like to share with and/or gather information from other service areas within the council, and with external service providers as appropriate to meet your needs.

Are there any services that you do not wish us to contact:

If Yes, please specify: Click here to enter text.

For Health Visitors only:

I give permission for registration at my local children's/Family centre: YES ☐ NO ☐

Using your Personal Information

The information you provide will be held on our database to help monitor the service we provide. We share and or gather information from private and voluntary organisations who may be involved in working with you and your family. Please note the only reason that information will be passed on without your consent is if there is a legal requirement to do so, or if there is a risk of serious harm or threat to life. Under the Data Protection Act you can see your own personal information. If you would like to know more about this, please ask for our leaflet, 'Access to your personal information' or contact the Data Protection Officer at Swindon Borough Council, Civic Offices, Euclid Street, Swindon SN1 2JH. Further information is available at http://www.swindon.gov.uk/cd/cd-dataprotection/Pages/cd-dataprotection.aspx

Sign to give your consent and confirmation of receipt of the privacy notice

I understand and agree to sharing of the information as shown above:

Signed: (Young person/parent/carer) **Signed:** (Worker)

Date: Click here to enter a date.

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