**Central London MHST (Mental Health Support Team) Referral Form**

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| **Referrer’s Details** | | | |
| **Name of Referrer** | Click or tap here to enter text. | **Date of referral** | Click or tap to enter a date. |
| **Address** | Click or tap here to enter text. | | |
| **Email Address** | Click or tap here to enter text. | **Phone Number** | Click or tap here to enter text. |
| **Relationship to child/young person:** | | | |
| **Details of the Child/Young Person** | | | |
| **First Name** | Click or tap here to enter text. | **Surname** | Click or tap here to enter text. |
| **Date of Birth** | Click or tap to enter a date. | **Age** | Click or tap here to enter text. |
| **Home Address** | Click or tap here to enter text. | **School Name** | Choose an item. |
| **Year Group** | Click or tap here to enter text. |
| **Gender** | Male  Female  Non-binary |
| **Is the gender the same as assigned at birth?** | Yes  No |
| **Mobile Number** | Click or tap here to enter text. |
| **Postcode** | Click or tap here to enter text. | **Email Address** | Click or tap here to enter text. |
| **Special Educational Need or Disability (SEND)** | | Yes  No  Don’t Know | |
| **Details of Special Educational Need or Disability** | | Click or tap here to enter text. | |
| **Religion** |  | **Sexual orientation** | Choose an item. |
| **Looked after child** | Yes  No |
| **Child protection plan** | Never been subject to a child protection plan  Previously been subject to a child protection plan  Currently subject to a child protection plan  Not known | **Accommodation status** | Mainstream housing  Other (please detail) |
| **Settled Accommodation Indicator** | Settled accommodation  Non-settled accommodation  Not known |
| **Ethnicity** | **Asian/Asian British**  Bangladeshi  Chinese  Indian  Pakistani  Any other Asian background  **Mixed/Multiple ethnic groups**  White and Black African  White and Black Caribbean  White and Asian  Any other mixed background | **Black/Black British**  Black African  Black Caribbean  Any other Black background  **White**  British  Irish  Any other White background  **Other ethnic groups**  Arab  Any other ethnic group  Prefer not to say | |
| **Does the child/young person have an Education Health and Care Plan (EHCP)?** | | | Yes NoDon’t Know |
| **Has the child/young person had a mental health intervention before (e.g. CAMHS, school counsellor, Educational Psychologist etc.)?** | | | Yes NoDon’t Know |
| **If yes, please give details:** | | | |
| **Details of the Main Parent/Carer** | | | |
| **Name** | | Click or tap here to enter text. | |
| **Contact details** | | Click or tap here to enter text. | |
| **Other parent/carer name and contact details** | | Click or tap here to enter text. | |
| **Who has parental responsibility?** | | Click or tap here to enter text. | |
| **Learning/physical disability** | | Yes NoRather not say | |
| **If yes, please specify:** | | Click or tap here to enter text. | |
| **Preferred Language(s)** | | | |
| **Main language of child/young person** | | Click or tap here to enter text. | |
| **Is an interpreter required? If so specify language** | | Click or tap here to enter text. | |
| **Main language of parent/carer** | | Click or tap here to enter text. | |
| **Is an interpreter required? If so specify language** | | Click or tap here to enter text. | |
| **GP Details** | | | |
| **Name** | Click or tap here to enter text. | **Phone Number** | Click or tap here to enter text. |
| **Full Practice Address** | Click or tap here to enter text. | **Email (*if known)*** | Click or tap here to enter text. |
| **Details of Other Agencies/Professionals Involved** | | | |
| **Name** | Click or tap here to enter text. | | |
| **Address** | Click or tap here to enter text. | | |
| **Phone Number** | Click or tap here to enter text. | | |
| **Email** | Click or tap here to enter text. | | |
| **Any other agencies involved** | Click or tap here to enter text. | | |

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| **Reason for Referral: please tick all relevant boxes** | |
| **PRIMARY SCHOOL** | **SECONDARY SCHOOL (11 years +)** |
| Mild to moderate anxiety: worries, irrational fears and concerns | Mild to moderate anxiety: worries, irrational fears and concerns |
| Common challenging behaviours (if aged between 5 to 8 years) | Family relationship difficulties |
|  | Low mood: sadness, low motivation |
|  | Peer relationship difficulties |
|  | Difficulty regulating emotions |
|  | Difficulty adjusting to change and transition |
| **Please give a brief summary of the difficulties the child/young person is experiencing** *(including background information, strengths and existing support)* | |
| Click or tap here to enter text. | |
| **Please identify any hopes or goals for the child/young person?** | |
| Click or tap here to enter text. | |
| **Any other relevant information** *(family, social and educational factors)* | |
| Click or tap here to enter text. | |

**YOUNG PERSON CONSENT FORM**

**(required if the young person is 13 years old or over)**

***N.B For children and young people aged between 13 and 16 years, consent must obtained from both the child/young person and parent/carer/guardian.***

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| **Consent – if this section is not completed fully, the referral will be returned to you prior to triage** | | | | |
| **Consent for referral** | | | | |
| Does the young person consent to this referral to mind? | | Yes | | No |
| **If the young person is 16 years and over**, does the young person consent to this referral being shared with their parents/carer/guardians? | | Yes | | No |
| **Consent for data processing** | | | | |
| In order to provide this service, Mind in Brent, Wandsworth and Westminster (BWW) will need to process data relating to the child / young person. Does the young person consent to this? | | Yes | | No |
| **Consent for data sharing**  Information you share with us is confidential between you, our service and your GP. The only time we will break this confidentiality is if we are concerned that there is a serious risk of harm to you or someone else. We store information on our Database system. This is confidential and cannot be accessed by anyone outside of our service. We do share anonymous information with NHS England and other statutory bodies that monitor our performance. This information may include details on the number of people we see, what type of treatment they receive, or if they recovered. This does not include your name, address, contact details etc. You have the right to opt-out of your confidential patient information being used by the NHS. If you wish to do so please visit the following website: <https://www.nhs.uk/your-nhs-data-matters/> Alternatively, you can call 0300 303 5678 to opt out. | | | | |
| Services with which data may be shared:   * A service that the client is already accessing / due to access / has recently accessed. * A new service (referral) that would benefit the client *(The client requires a different service from what is being offered by BWW Mind)* * NHS England’s Mental Health Services Data Set   *This is a national data set, which collects data on all clients in England receiving emotional wellbeing and mental health services through NHS-funded interventions.* | | | | |
| I agree to give my consent for Brent, Wandsworth and Westminster Mind to use my anonymised feedback on the following:  •             Use on printed annual reports, leaflets or any publicity material, & in events/exhibitions  •             On the charity’s websites  •             Share with commissioning agencies | Yes | | No | |
| **Child/Young person’s Name:**Click or tap here to enter text.  **Signature (required if aged 13 or over):**  **Date:** Click or tap to enter a date. | | | | |

**VIDEO CONSENT FORM**:

As your practitioner, I have regular supervision with my clinical supervisor, to discuss my work. In order to help the quality of my supervision, I am asking for your permission to video-record our sessions. I may show part(s) of the session to my supervisor in order to talk about ways of working that might be helpful to you/your child. This enables me to develop my skills as a practitioner and attend to your/your child’s therapeutic needs. No-one else would have access to the video.

The video would also be available for you to watch the session again, should you wish to. **Please read the following paragraphs and, if you are in agreement, sign where indicated.**

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| **Video Consent** | | |
| I have read and understood the video consent form information | Yes | No |
| **I give my verbal consent for my sessions to be recorded:**  I understand that my practitioner will check at the start of each session if this is still okay and will ask for my verbal consent on each tape as well: | Yes | No |
| I understand that my consent may be withdrawn at any time. | Yes | No |
| **Child/Young person’s Name:**Click or tap here to enter text.  **Parent/Carers Name:** Click or tap here to enter text.  **Signature (required if aged 13 or over):**  **Name of Practitioner:** Click or tap here to enter text.  **Date:** Click or tap to enter a date. | | |