**CAMHS Request for Help**

**Parents / Carers / Young People**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Child/Young Person |  | Date Of Birth |  |
| Address |  | Age: |  |
| NHS Number (if known) |  | Telephone Numbers – Please say who they belong to (Parent / Young Person) | Home |
| Email Address |  | Mobile |
| Who is filling this form in? |  | Today’s Date: |  |
| What School / College do you go to? |  | Who should we speak to in School / College? |  |
| GP Surgery |  | Ethnicity |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Have you attached a Consent for Information Sharing form? |  | Yes |  |  | No |  |

|  |  |
| --- | --- |
| Parent/Carer Name |  |
| Parent/Carer Address |  |
| Who has Parental Responsibility? |  |
| Telephone Number |  |

**Who is currently involved with you / in your young person’s care?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| School PSA |  | School Nursing Service |  | Child Development Centre |  |
| Kooth |  | Young Devon |  | Social Care |  |
| The Zone |  | MAST |  | Communication Interaction Team |  |
| SHARP |  | Other (please specify) |  |  |  |

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| --- |
| **Why would you like help from CAMHS - The reasons for your request:**  **(The electronic version of this form will expand this box. If completing on paper please attached any additional pages)** |
| **What outcomes / goals would you like to achieve if you were helped by CAMHS:**  **1.**  **2.**  **3.** |
| **Is there any other important information you would like to share to help us understand you / your young person?**  **Have you / your young person previously been involved with CAMHS?**  **If we need to know more about you / your young person how would you like us to contact you?**  **Telephone Email Post** |

**Risk Factors**

**Are there any current/past child protection or risk issues such as:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Self Harm |  | Suicidal Ideation |  | Domestic Abuse |  |
| Housing |  | Known historical abuse |  | Risk of exclusion from education |  |
| Bullying |  | Parental Mental Health |  | English as additional Language |  |
| Other |  | Risk of sexual exploitation |  | Risk of radicalisation |  |
| Other Risk Factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

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| **If you / your young person are at risk of suicide, this request is not for urgent support - Please contact your GP or a professional involved with you to discuss a safety plan and make an urgent request to CAMHS.** |

**Please Email this Request For Help form to:**

[**livewell.camhsearlyhelp@nhs.net**](mailto:livewell.communitycamhs@nhs.net)

**Or Post to:**

**CAMHS Community Team, Admin Block – 1st floor, Mount Gould Hospital, Mount Gould Road, Plymouth, PL4 7QD**

**Consent to share information**

**Consent-** This means you are agreeing to share personal information.

We would like your consent to contact any agencies that are currently involved or who we consider may be of help. 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, e.g. child protection concerns. You will be told of this.

Please tick the box if you are agreeing to use the CAMHS text reminder service. This will remind you of day and time of your appointment.

Yes No

If yes, please provide the mobile number Telephone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I agree to information being shared between agencies to help me/my child:**

|  |  |
| --- | --- |
| Name of child/young person |  |
| Signature |  |
| Date |  |
| Signature of principal parent/main carer |  |
| Date |  |

**Please indicate here any agencies/persons you would not want us to contact**

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|  |