Government of **Western Australia**
Child and Adolescent Health Service

Community CAMHS referral form

If you need urgent mental health advice
Call the CAMHS Crisis Connect on 1800 048 636, 24 hours a day, 7 days a week

Please read the following before proceeding to complete this referral

As a specialist mental health service, Community CAMHS will prioritise seeing children and young people experiencing severe, complex and persistent mental health symptoms that impact on psychosocial functioning (at home, school or socially), and/or who present with significant risk due to their mental health difficulties.

Neurodevelopmental concerns: For assessment and/or management of Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, or Foetal Alcohol Spectrum Disorder, including management/prescription of stimulant medications, consider contacting Child Development Services, and/or private Paediatricians.

Mild to moderate mental health concerns: consider a referral to Headspace, Youthfocus a therapist via your GP under Medicare's Better Access initiative, or other counselling services in the community.

The reason for entry to CAMHS must primarily relate to severe and complex mental health problems, although other concurrent and/or associated difficulties may exist (e.g. autism, intellectual disability, and child protection issues). The range of presenting problems usually accepted on referral includes (but is not limited to):

- Psychotic symptoms (consider a referral to the headspace Youth Early Psychosis Program. Click on this link to see if there is a program in your area)
- Severe and complex mood related symptoms;
- Severe and complex anxiety symptoms (e.g. severe generalised social anxiety, obsessive compulsive disorder, panic disorders, phobias);
- Persisting suicidal ideation, attempted suicide, and/or serious risk of harm to self or others due to severe and complex mental health problems;
- Eating disorders;
- Co-morbid severe and complex mental health symptoms related to substance use; and
- Severe and complex symptoms resulting from trauma

To find the clinic that covers your patient's postcode, please refer to the list of Community CAMHS clinics.

Referrer details

Name: _____

Profession: _____

Agency/GP Practice name: _____

Address: _____

Phone: _____ Mobile: _____ Fax: _____

Email: _____

Have you directly assessed the patient? Yes ☐ No ☐ Date of last assessment: _____

Has a parent/carer consented to this referral? Yes ☐ No ☐

Patient details

Legal Name: _____ Surname: _____

Sex as registered at birth: M ☐ F ☐ Intersex or other (please specify): _____

Date of birth: _____ Preferred name: _____

Identified Gender: M ☐ F ☐ Other _____ Preferred pro-nouns _____

Primary Address: _____

_____ Postcode: _____

Phone: _____ Mobile: _____

Email: _____

Medicare number: _____ Ref: _____ Expiry: _____

Have you asked what culture the young person identifies with? Yes ☐ No ☐

Aboriginal and Torres Strait Islander ☐ Aboriginal ☐ Torres Strait Islander ☐

Other ethnicity: _____

Preferred language: _____

Interpreter required? Yes ☐ No ☐ Preferred gender of interpreter: M ☐ F ☐

Current school: _____ Year: _____ Phone: _____

Parent or carer details

1. Name: _____ Phone: _____

   Email: _____ Relationship to child: _____

2. Name: _____ Phone: _____

   Email: _____ Relationship to child: _____

3. Name: _____ Phone: _____

   Email: _____ Relationship to child: _____

Presenting mental health difficulties

Describe the presenting problems, including onset, duration and frequency. Describe how the problems impact on the young person's functioning (eg at home, school or socially)

Has a previous diagnosis been made? By whom (name, profession and service/agency)?:

_____

Other health or development issues

Risk issues

Do you feel that the child is ***currently*** at risk due to their mental health difficulties they experience? (*eg deliberate self-harm, suicidal thoughts, risk to others)* Yes ☐ No ☐

Is there a current Safety Plan? If so then please describe this. Yes ☐ No ☐

Please describe below the details regarding risk:

Child protection issues

Are there **unaddressed** concerns such as abuse, neglect, lack of supervision or homelessness?
Yes ☐ No ☐

Are Child Protection Services involved? Yes ☐ No ☐

Other agencies or care providers - *Current and previous*

Agency: When:

Contact person: Phone:

Agency: When:

Contact person: Phone:

Agency: When:

Contact person: Phone:

If any of these agencies are current, are they aware of your referral? Yes ☐ No ☐

Further comments and matters of concern