



# 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, recent suicide attempt, 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: .....

### GP Practice and Provider Details (if not referrer)

Practice Name: .....

Practice Address: .....

..... Postcode: .....

Phone: ..... Fax: .....

Email: .....

Name of GP: .....

### Next of kin

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 (e.g. at home, school or socially)*

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

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### 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?  
(e.g. 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

Is the child in the care of the Chief Executive, Department of Communities?

Yes  No

Are Child Protection Services involved? Yes  No

If yes, please provide contact details of case manager:.....

Are there unaddressed concerns such as abuse, neglect, lack of supervision or homelessness?

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