**Section One: Demographic details - *to be completed by referring professional***

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| **Referrer Details *(school to complete)*** |
| Name: |  | Job title: |  |
| School/College: |  |
| Email address: |  | Contact no: |  |
| Date of Referral: |  |
| Is there an EHCP in place? | Yes/No | Is the child/YP on the SEND Register? | Yes/No |
| Attendance Level: |  | Academic Level: | Below/Meeting/Exceeding |

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| **Child /Young Person’s Details: Child (4-12 years), Young Person (13-18 years)** |
| First Name: *(as registered with the GP)* |  | Date of Birth: |  |
| Last Name: (as registered with the GP) |  | Age: |  |
| Name*: (Also Known As)* |  | Year group: |  |
| Pronouns: |  | Gender at birth: |  |
| Home address: |  |
| Are any adjustment needed to fully access the service? *Eg. Interpreter, large print letters etc. If so please provide details* |  |
| GP Practice: |  | NHS No: *(if known)* |  |
| **Contact Details:** *(parent/carer needs to have legal responsibility)* |
| Young Person Email: |  | Young PersonMobile No: |  |
| Who is completing the referral with school? | Young Person / Parent/Carer  | Parent/Carer aware of referral? | Yes / No |
| Parent/Carer Name: |  | Relationship: |  |
| Parent/Carer Email: |  | Occupation: |  |
| Home Address: |  |
| Home Tel. Number: |  | Parent/Carer Mobile: |  |
| Are any adjustment needed to fully access the service? *Eg. Interpreter, large print letters etc. If so please provide details* |  |
| **Family / Household Composition** |
| Name | Relationship to Child/ Young Person | Date of birth/ Age | Occupation/School | Reside at the home address? |
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**Section Two: Referral details - *to be completed by referring professional***

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| **Reason for Referral** Please include:* The child / young person’s voice *(for example, child / young person feeling anxious or lonely)*
* Difficulties - history, context of the difficulties
* Family/environmental factors, risks *(past and current)* and strengths in the system
* What has been tried/ is in place already
* Details of any diagnosis
* Safeguarding
* Attendance levels
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| **Other Agencies currently involved:** |
| Agency | Name/Role | Contact Details |
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| **Intervention requested (please tick)** |
| Group work |[ ]  Consultation appointment with school/college |[ ]
| For secondary age young people - Anxiety  |[ ]  Consultation appointment with young person/family |[ ]
| For secondary age young people - Low Mood  |[ ]  Support with referral or signposting to other appropriate service |[ ]
| For primary age children - Anxiety |[ ]  Other (please specify): |[ ]
| For primary age children - Behaviour Work  |[ ]   |[ ]

**Consent Confirmation: *to be completed by Young Person (13-18 years) or parent/carer (4-12 years)***

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| **Child/Young Person’s Name:** |  |

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| [ ]  | I am a young person, consenting for myself | [ ]  | I consentfor my parents/carers to be contacted in relation to this referral. *If you* ***do not*** *agree please let us know the reasons, this will not affect your referral.* |
|[ ]  I am a parent/carer, with parental responsibility, consenting for my child. |

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| *Please read the following statements carefully, tick the appropriate boxes and sign the form. Please note if you do not consent to all of the statements, we may not be able to offer you a service. Further explanation of the statements below can be found on page 4 of this form or please contact the MHST if you have any further queries.* ***ccs.mhst@nhs.net*** |
| **CONSENT STATEMENTS Please tick to indicate consent** | **YES****I Consent to all** | **NO****I Do Not Consent** |
| **I consent for a record to be opened with the Mental Health Support Team** *(part of the Emotional Health and Wellbeing Service). If we do not open a record, unfortunately we are unable to offer you any kind of service****. ‘****Open record.’* | [ ]  |  |
| **I consent for information to be shared out with other organisations.** *If you do not agree please let us know the reasons for this as we might not be able to offer you a service. ‘Sharing out****.’*** |
| **I consent for the MHST to view what is recorded by other care services. ‘Sharing in.’** |
| **I consent to receiving consultation/treatment. ‘Treatment.’** |
| **I agree that I have read and I understand the confidentiality agreement.** *‘Confidentiality and information sharing agreement.’* |
| **I consent to receiving face-to-face care or via video conferencing on MS Teams.** |
| **I consent to the MHST and the wider CCS NHS Trust sending me SMS messages relating to the care of the child/young person**.*We may send text (SMS) messages for appointment reminders and share any other useful information about your health. Please ensure we have your correct mobile phone number if you would like to receive these. If you do not want this service please indicate by ticking in the right column that you do not consent.* |
| **To Confirm, my mobile number is:**  |
| **Email Communication with parent/carer/YP/school - I consent to receiving email communications from the EHWS and the wider CCS NHS Trust relating to the care of the child/young person.***We will send information to you using email from an* *@nhs.net* *address, this can include personal, sensitive and patient identifiable data. First, we will send a verification email to confirm we have the right details.* ***We will not send any information without verification****. Once any information has left our secure NHS email accounts, the security of the information is your responsibility.By consenting to this you are authorising the use of this email address in relation to this patient record within the wider Cambridgeshire Community Services NHS Trust.**The Trust has no responsibility for information that leaves the authorised NHS network at the request of the patient and as such cannot guarantee the security of such information and by consenting you confirm that you have read and understood the conditions above.*  |

**PLEASE NOTE THE FOLLOWING REQUIREMENTS REGARDING CONSENT SIGNATURES:**

***Incorrectly completed forms will be returned, which may delay the referral process.***

**For young people at secondary school/college students:**

* Young people aged 11 & 12: **BOTH** Parent/Carer **and** the Young Person MUST sign and date below.
* Young people aged 13 & above: the **Young Person** MUST sign and date the below. A parent/carer can also sign if they wish but this is not essential.

**For children at primary school:**

* A parent/carer must sign and date below.

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| --- | --- | --- | --- |
| **Parent/Carer Name:**  |  | **Date:** |  |
| **Signed:** |  |
| **Young Person name:** |  | **Date:** |  |
| **Signed:** |  |

**Parent/Carer/Young Person - A copy of this form will be retained on your child’s/your health record.**

**Schools - Please return the completed form to the MHST inbox:** **ccs.mhst@nhs.net** **and provide a copy for the parent/carer/young person. A copy of this referral form can be kept for future reference provided it is stored securely in line with GDPR requirements.**

**Information for Schools**

**Please note:**

* We can only accept a referral if the client/client’s representative has given consent for their health record to be opened – please ask the Young Person / parent/carer to complete the consent section.
* Schools and colleges have a number of referrals that they can submit per term. For this reason all referrals need to be overseen and submitted by the Mental Health Lead.

**The Mental Health Support Team offers the following three functions:**

F1. We provide individual and group evidence-based interventions with young people and families in relation to mild to moderate mental health needs specifically anxiety, behavioural issues and low mood. These are carried out with the parents of primary aged children and directly with the young person in a secondary or post-16 education setting. The interventions are based on Cognitive Behavioural Therapy informed Guided Self Help strategies.

F2. We work with education settings to promote a ‘Whole System Approach’ to improve the mental health of the whole organisation, including the wellbeing of staff. This includes staff training.

F3. We offer consultations with school staff and/or clients who may not be appropriate for a direct intervention. We link with other agencies and are able to support referrals and signpost.

**Information for Parents/Carer/Young Person:**

**CONFIDENTIALITY AGREEMENT AND INFORMATION SHARING**

To help us provide the best support to our clients we write records in the NHS electronic system. A limited version of these notes can be viewed by other NHS health professionals such as your GP. A more detailed version of our notes is recorded and can be viewed internally within the Mental Health Support Team and the wider Emotional Health and Wellbeing Service (provided by Cambridgeshire Community Services NHS Trust).

If appropriate, we will share information with other partners who may be able to provide Health, Education or Social Care support to you. The two main reasons for sharing information outside our service will be:

* Due to concerns in relation to risk, (to you or to others). If this circumstance arises we will advise you, where safe to do so, of the concerns and contact the appropriate agency.
* To connect you with other services that might support your needs better than us.

In addition to this, practitioners discuss cases within the team and with their supervisors. This is a process for ensuring safe practice and quality of interventions.

**VIDEO CONFERENCING AND FURTHER CONFIDENTIALITY CONSIDERATIONS**

The Mental Health Support Team offers a mixture of face to face, telephone or video consultations, depending on government directives as to safe working practices.

You agree that you will not record sessions, partially or in full at any time.

We have Trainee Education Mental Health Practitioners (TEMHPs) within our service. As part of their training, our TEMHPs are required to submit recordings of some of their sessions. They will therefore need to record some of their sessions and the recordings will be stored safely in accordance with Trust and GDPR guidelines. The recordings will be submitted to their University course for assessment and learning purposes. **You will be asked permission for a session to be recorded.**

**Health Record**

Your signed form allows us to open a clinical record in your NHS notes. The information we gather and process will be stored on your health record and managed in accordance with the NHS Records Management Code of Practice. A copy of which you can find via our website: <https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016>

We have a Privacy Notice that sets out what we use your data for and how you can exercise your data rights. Please note we do not rely on consent as a lawful basis for processing your data. The consent we are asking for is to share your confidential information. A copy of the Privacy Notice can be found at:

<http://www.cambscommunityservices.nhs.uk/docs/default-source/ig-privacy-notices/pn-children-39-s-specialist-services-v1-2-sept-2018.pdf?sfvrsn=10>

Young people and parents of young children are able to access their records. You can place an Access to Records (ATR) request by emailing directly ccs.accesstoinfo@nhs.net

**Every member of our staff has an obligation to protect confidentiality**

**Data Protection Officer:** ccs.accesstoinfo@nhs.net

Cambridgeshire Community Services NHS Trust Unit 7/8, Meadow Lane, St Ives, Cambs, PE27 4LG.

If you would like to request a copy of your record, please contact the Access to Records Department on ccs-tr.accesstorecords@nhs.net

Information about your data and rights can be accessed via:

<https://www.cambscommunityservices.nhs.uk/docs/default-source/leaflets---pals---april-2015/0253-your-data-your-rights.pdf>

For further information on your rights under GDPR, or to exercise these rights, please contact the Information Governance team on ccs.accesstoinfo@nhs.net