REFERRAL TO :

Bromley Community Wellbeing Service ☐
School Wellbeing Service ☐
Traded Services ☐

If you are a professional the section above must be completed before a referral can be processed

PERSONAL DETAILS				
DATE OF REFERRAL			**NHS No:**	
FIRST NAME			**School ID:**	
SURNAME				
DATE OF BIRTH				
GENDER (*Please select)*	☐ Male	☐ Female	☐ Other	
ETHNICITY ***(Please select)***	☐	White - British	☐	Black or Black British - African
	☐	White - Irish	☐	Other Black background
	☐	Other White background	☐	Mixed - White & Black Caribbean
	☐	Asian or Asian British - Indian	☐	Mixed - White and Black African
	☐	Asian or Asian British - Pakistani	☐	Mixed - White and Asian
	☐	Asian or Asian British - Bangladeshi	☐	Other Mixed background
	☐	Other Asian background	☐	Any other Ethnic group
	☐	Chinese	☐	Not known
	☐	Black or Black British - Caribbean	☐	Information refused
DISABILITY STATUS ***(If the young person is considered to have a disability, please select the type of impairment)***	☐	Deaf or Hearing Impairment		
	☐	Blind or Visual Impairment		
	☐	Speech Impairment		
	☐	Physical/Mobility Impairment		
	☐	Diagnosed Mental Health Condition		
	☐	Learning Disability/Difficulty e.g. dyslexia		
	☐	Diagnosed Social/Communication Impairment e.g. ASD/ADHD		
	☐	Long-term/Progressive Conditions e.g. Cancer, Multiple Sclerosis, Epilepsy, Diabetes		
	☐	Information refused		
	☐	Other (please specify):		
	☐	Currently Being Assessed (please specify):		

PARENT/CARER NAME		
HOME ADDRESS		
POSTCODE		
PRIMARY CONTACT FOR REFERRAL	☐ Young Person ☐ Parent ☐ Carer **The primary contact is the person who will be contacted regarding all appointment details and with follow-up information if necessary.**	
PRIMARY CONTACT EMAIL ADDRESS		
PRIMARY CONTACT MOBILE NUMBER		
ADDITONAL TELEPHONE CONTACT NUMBERS	**Parent/Carer (if applicable)**	
	Young Person (if applicable)	
PREFERRED METHOD OF CONTACT	☐ Email ☐ Telephone call ☐ Text message ☐ Post **Select one of the above – alternative methods may also be used.**	
IN SCHOOL/TRAINING **NAME OF SCHOOL**	☐ YES ☐ NO **If yes, please provide name of school below:**	
GP SURGERY		
REFERRER DETAILS	**Referrer's Name**	
	Referral Agency	
	Referrer Telephone	
	Referrer Email	
PRIMARY LANGUAGE SPOKEN		
INTERPRETER REQUIRED	☐ YES ☐ NO	

CONSENT AND STATUS

Bromley Y securely stores personal information about children and young people who are referred to all its services. This information may be shared with other professionals (such as health/care professionals) only when necessary for care/treatment and all information is protected under data protection law. If clients do not want information to be stored or shared for the above reasons relating to treatment/care, their referral cannot be accepted by the service. For further details please view the service privacy policy: https://www.bromleywellbeingcyp.org/how-to-refer/

Please note: Consent can be provided by the young person over 16 years if they are judged capable of understanding what this means. If the client is under 16, consent should be provided by a parent/carer. Consent from parents/carers must be provided in writing by email (attached to this referral form) or by signing in the consent box below. In exceptional circumstances, a child under the age of 16 may consent to a referral if they are deemed Gillick competent (https://www.nhs.uk/conditions/consent-to-treatment/children/).

CONSENT GIVEN FOR REFERRAL FROM*	**PARENT/CARER** ☐ YES	Signed:	☐ NO
	YOUNG PERSON ☐ YES	Signed:	☐ NO
IS THE YOUNG PERSON A 'CHILD LOOKED AFTER'?	☐ YES ☐ NO **If yes, which local authority holds parental responsibility?**		
IS THE CHILD CURRENTLY THE SUBJECT OF ANY OF THE FOLLOWING:	**Child In Need** **YES** ☐ **NO** ☐ **Child Protection Plan** **YES** ☐ **NO** ☐ **(If yes we may request permission to receive a copy of this plan)** **CAF** **YES** ☐ **NO** ☐		
ARE THERE ANY ONGOING LEGAL PROCEEDINGS?	☐ **YES** ☐ **NO** **If yes, please provide further details:**		
SOCIAL WORKER'S CONTACT DETAILS	**Name**		
	Telephone		
	Email Address		
OTHER PROFESSIONALS/ AGENCIES CURRENTLY INVOLVED e.g. Bromley Children's Project (BCP), Common Assessment Framework			
CURRENTLY RECEIVING SUPPORT IN SCHOOL?	☐ YES ☐ NO	If yes, please explain (eg. school counselling, Wellbeing workshops or Wellbeing groups) :	
EHC (EDUCATION, HEALTH AND CARE) PLAN IN PLACE?	☐ YES ☐ NO		

DURATION OF DIFFICULTIES ***Please select (X) the appropriate boxes and give more detail on last page***		
Less than one month ☐	Less than 3 months ☐	More than 3 months ☐

FAMILY DETAILS ***Please select (X) the appropriate boxes and give more detail on last page***
Are any other family members currently being support by any of our services? **Bromley Community Wellbeing** ☐ **School Wellbeing Service** ☐ Please give the family member's name if you wish to:

REASONS FOR REFERRAL ***Please select (X) the appropriate boxes and give more detail on last page***	
☐	Anxiety specifically related to COVID19
☐	General anxiety
☐	Transition difficulties
☐	Bullying
☐	Sexual identity
☐	Bereavement
☐	Gender identity
☐	Conflict with parents
☐	Past sexual abuse
☐	Children whose parents have a mental health, drug and/or alcohol difficulties
☐	Panic attacks (overwhelming fear, heart pounding, breathing fast etc.)
☐	Changes in mood (low mood – sad, apathetic; high mood – exaggerated / unrealistic elation)
☐	Sleep disturbance (difficulty getting to sleep or staying asleep)
☐	Eating difficulties(change in weight / eating habits, negative body image, purging or binging)
☐	Difficulties following traumatic experiences (e.g. flashbacks, powerful memories, avoidance)
☐	Hyperactivity (levels of overactivity & impulsivity above what would be expected; in all settings)
☐	Psychotic symptoms (hearing and / or appearing to respond to voices, overly suspicious)
☐	Delusional thoughts (grandiose thoughts, thinking they are someone else)
☐	Depressive symptoms (e.g. tearful, irritable, sad)
☐	Obsessive thoughts and/or compulsive behaviours (e.g. hand-washing, cleaning, checking)
☐	Oppositional Defiant Disorder
☐	Soiling / Enuresis
☐	Behavioural difficulties
☐	Attention Deficit (ADHD)
☐	Risk of child sexual exploitation (CSE)
☐	Young carer
☐	Phobias (eg. animals, blood)
☐	Social/communication difficulties (e.g. suspected undiagnosed ASD)

HARMING BEHAVIOURS	***Please select (X) the appropriate boxes and give more detail below.***
☐	History of self-harm (cutting, burning etc.)
☐	History of thoughts about suicide
☐	History of suicidal attempts (e.g. deep cuts to wrists, overdose, attempting to hang self)
☐	Current self-harm behaviours
☐	Anger outbursts or aggressive behaviour towards children or adults
☐	Verbalised suicidal thoughts* (e.g. talking about wanting to kill self / how they might do this)
☐	Thoughts of harming others* or actual harming / violent behaviours towards others

More information on the Harming Behaviours box/boxes ticked above

Social setting - for these situations you may also need to inform other agencies (e.g. Child Protection)			
☐	Family mental health difficulties	☐	Living in care, Child Looked After
☐	History of bereavement/loss/trauma	☐	Involved in criminal activity
☐	Problems in family relationships	☐	History of social services involvement
☐	Problems with peer relationships	☐	Current Child Protection concerns
☐	Not attending/functioning in school	☐	History of domestic violence
☐	Excluded from school (FTE, permanent)	☐	Housing difficulties
☐	Physical health difficulties	☐	Unemployment
☐	Identified drug / alcohol use	☐	Gang involvement

INVOLVEMENT WITH CAMHS	***Please select (X) the appropriate boxes and give more detail on last page***	
☐	Current CAMHS involvement	
☐	Previous history of CAMHS involvement	- Less than 6 months ago
☐		- More than 6 months ago
☐	Consent to receive discharge summary from CAMHS	
☐	Previous history of medication for mental health difficulties	
☐	Any current medication for mental health difficulties	
☐	Developmental difficulties e.g. ADHD, ASD, LD	

What are the referrers hopes for the outcome of this referral?

What are the concerns regarding the young person's mental health? *(Please include the views of the young person, family, and others. Please describe how it is affecting the young person's daily life)*

If you have any queries when completing this form, please call the Referrals Team on 0203 770 8848.

When complete, please return by email BROCCG.bromleyy@nhs.net This will be processed by the referrals team and you will receive a confirmation email.

If you do not get a confirmation email within 48 hours, please call to ensure this has arrived safely

Alternatively, you can post to Bromley Y, 17 Ethelbert Road, Bromley BR1 1JA.

What happens next?

Once this referral form has been received by the Bromley Y Referrals Team, it will be processed and if all required information has been provided, a triage assessment will be conducted. A member of staff will be in touch with the primary contact following this initial triage assessment.

Please ensure that all contact details provided are up to date. These details will be used to verify identity and for the service to communicate with clients about the outcome of the referral, interventions and further care.