ARC: Referral form for Children and Young People’s Asylum Seekers and Refugees Clinic

Please note we do not accept referrals from Hospital Assessments or Inpatient settings. Please refer to your local CAMHS service.

**Please make sure that all of the information is fully completed and the CRIES-13 questionnaire included at the end of this form is filled out before submitting the referral. Please note that referrals will not be accepted if there is no completed questionnaire.**

 Please email this completed form to awp.camhsarc@nhs.net.

|  |
| --- |
| **For Office Use Only** |
| **NHS Number:** |  | **IAPTUS ID:** |  |
| **Accompanied?**  | **Yes / No** | **Date Received:** |  |

|  |
| --- |
| **Details for Young Person being referred** |
| **Surname (s):** |  | Date of Birth: |  |
| Forenames: |  | Age: |  |
| **Known as:** |  | Gender: |  |
| Ethnic Category (Please X one box only) | Country of Origin |  |
| **White** | Mixed | **Asian/Asian British** | **Black/Black British** | **Other Groups** |
| British |  | White & Black Caribbean |  | Indian |  | Caribbean |  | Chinese |  |
| Albanian |  | White & Black African |  | Pakistani |  | African |  | Vietnamese |  |
| Other |  | White & Asian |  | Bangladeshi |  | South Sudanese |  | Iranian |  |
|  |  | Other |  | Afghan |  | Sudanese |  | Syrian |  |
|  |  |  |  | Other |  | Other |  | Other |  |
| **Current Address:** |  |
| Is the address confidential? | **Yes / No** |
|  | Mark with X | **Name of:**(select appropriate)**Parent /Foster Carer /Adopter /Key worker at Residence** |  |
| **Living with Parents** |  |
| **Agency Foster Carer** |  |
| **Bristol Foster Carer** |  |
| **Residential Unit** |  | **Name of Residence**(if applicable) |  |
| **Residential School**  |  |
| **Adopted** |  | **Email:** |  |
| Date adopted: |  |
| **Other**  |  | **Telephone number:** |  |
| Please specify: |  |
| **Who has Parental Responsibility?** |  |
| **Have they agreed to this referral?**  | **Yes / No** | **Is the child aware of this referral?** | **Yes / No** |
| **Child / Family’s first language:** |  |
| **Is an interpreter required for child?** | **Yes / No** | **Is an interpreter required for parents/carers?** | **Yes / No** |
| **Language Interpreter required:** |  |
| **Does the child have a disability?** | **Yes / No / Prefer not to say / Unknown** |
| Are any adjustments needed? |  |

|  |
| --- |
| **Legal Status of young person:** |
|  | Mark with X | **Date arrived in UK:**  |  |
| Asylum Seeker |  |
| Refugee |  | Age Assessment completed?  | Yes / No |
| Leave To Remain |  |
| For how long: |  | Statement of Evidence Form (SEF) submitted | Yes / No |
| Other |  |
| Please specify: |  | (if yes then please include as part of the referral if possible) |

|  |
| --- |
| **Referral made by**  |
| **Name:**  |  | **Email Address:** |  |
| **Organisation** |  | **Job Title:**  |  |
| **Tel No:** |  | **Mobile:** |  |
| **Address:** |  |

|  |
| --- |
| **Details of professionals involved** |
| **GP Practice:** |  | **GP Name** (if known)**:** |  |
| **Address and Telephone no:** |  | **Email:** |  |
| **Social Worker:** |  | **Base:** |  |
| **Email:** |  | **Tel No:** |  |
| **Name of School / Nursery / College** |  | **Address:** |  |
| **Name of contact:** |  | **Contact role:** |  |
| **Email:** |  | **Tel No:** |  |
| **Other relevant professionals e.g. Family social workers, Advocate, Solicitor, etc.** |
| **Name** |  | **Email:** |  |
| **Organisation** |  | **Job Title:**  |  |
| **Name** |  | **Email:** |  |
| **Organisation** |  | **Job Title:**  |  |
| **Name** |  | **Email:** |  |
| **Organisation** |  | **Job Title:**  |  |

|  |
| --- |
| 1. Reason for Referral |
|  |
| 2. What actions / outcomes are you seeking? |
|  |
| **3. Please put and X in the box for which area of support is needed for this child, using the i-Thrive model:**  |
| Getting Advice |  | Getting Help |  |
| Getting Risk Support  |  | Getting More Help |  |
| e.g. Sign-postingInformation One off consultation e.g.AssessmentShort-term intervention(CREATE, a psychoeducation group for trauma stabilisation)Network training(CREATE for carers and professionals)e.g. Therapy for trauma and PTSD (EMDR, CATT, Art therapy)e.g. Risk management meetingsTAF meetings  |
| 4. Current concerns / Presenting problemsWhat are the acute triggers for seeking help now?How long, how severe, how does it impact on the child, their home life, and their education? |
|  |
| **5. What has been tried before and what was the response?** |
|  |
| **6. What information do you have about the young person’s family or journey?**Is the Red Cross Family Finding Service involved?If available please attach SEF instead of answering this question. |
|  |

|  |
| --- |
| **Consent to share information: Due to COVID-19 we are aiming to do our consultations by telephone or video, which we require consent.** To provide the best possible care we might need to share personal information with others who are involved in this child or young person’s care (e.g. GPs, Education). Information is only shared on a need to know basis and will always be completed securely, in line with legal responsibilities. We will discuss who we may be sharing information with and the reasons for this with you.You can withdraw consent to share information at any time by informing the relevant professional if you wish to do so. However, if consent is withdrawn it may affect the care we are able to offer. We will discuss the possible effect this may have with you.There may be occasions where it is necessary to share information without your permission, where this is required by law, for example where it is in the public interest to protect somebody from significant harm. In these circumstances the information shared will always be kept to a minimum. |
| **Is there any information you prefer not to be shared or any person or organisation you would not want your information shared with?** | **No / Yes** |
| Details(if applicable) |  |
| **Signature of young person(must be able to understand the process of consent and be aged 12 or over)** |
| Signed: |  | Date signed: |  |
| **Signature of person giving consent on behalf of the young person, if young person not able to give consent themselves. Please include name and relationship to child and date the signature.**  |
| Name: |  | Relationship to young person: |  |
| Signed: |  | Date signed: |  |
| **Please make sure that all of the information is fully completed and the CRIES-13 questionnaire included at the end of this form is filled out before submitting the referral. Please note that referrals will not be accepted if there is no completed questionnaire.****Please also attach any other additional information e.g. Statement of Evidence Form**Email this completed form and supporting documents to awp.camhsarc@nhs.net**Specialist CAMHS for Asylum Seekers and Refugees Clinic (ARC)****Joan Johnson House****43 Ducie Road****Barton Hill****Bristol BS5 0AX****Tel No: 0300 124 5944** |

**If the young person is accompanied please can a parent or family member complete the below questionnaire. Please email the ARC clinic for translated questionnaires.**

**If the young person is unaccompanied please can the referrer and carer complete the below questionnaire.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Completed by:** |  | **Date completed:** |  |

CRIES-13 parent/carer version

The statements below are related to the after effect of a very frightening event (or events). Please tick the box that indicates how often the statement applied in the **past 7 days**. If the statement is true, just not in the past 7 days, tick “not at all”.

Name of your child: ......…………………………............ Date: …………………..................................

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Not at all** | **Rarely** | **Sometimes** | **Often** |
| 1.  | Do you have the impression that your child has to think about it often?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 2.  | Does your child try to put it out of his/her mind?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 3.  | Does your child find it difficult to pay attention or concentrate?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 4.  | Does your child have sudden surges of strong feelings?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 5.  | Does your child get startled more easily, or is she/he more nervous than before it happened?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 6.  | Does your child stay away from things that remind him/her of the event (like places or situations)?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 7.  | Does your child try not to talk about it?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 8.  | Does your child suddenly see images of the event in her/his mind or have bad dreams?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 9.  | Do other things keep making your child think of it?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 10.  | Does your child try not to think about it?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 11.  | Does your child get easily irritated or angry?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 12.  | Is your child overly cautious or on guard, even when there’s no clear need to be?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 13.  | Does your child have trouble sleeping?  | [ ]  | [ ]  | [ ]  | [ ]  |