**Solar - Request to Access Service (Referral) Form**

Solar is a partnership between Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo’s and Autism West Midlands and provides Emotional Wellbeing and Mental Health Services to Children, Young People and Families in Solihull.

Please return all forms to:

Once complete, please return this form to bsmhft.solihullcamhs@nhs.net, fax to 0121 301 2751 or post/hand deliver to **Solar, Bishop Wilson Clinic, Craig Croft, Chelmsley Wood, B37 7TR**

Please note we can only accept referrals for children and young people registered with a Solihull GP.

Please note this referral will be triaged by a clinician to decide the most appropriate Solar pathway:

* Solar Mental Health and Emotional Wellbeing Support
* The Eating Disorders Service (TEDS)
* Looked After Childrens Team (LATCH) – **For LATCH Referrals please complete Referral Part A and B**
* Learning Disability Team
* Crisis – *If you believe a Child or Young Person is in Crisis (Including suicidal thoughts with intent/plans/attempts) please seek urgent help by calling 0121 301 5500 (open 8am-8pm) for out of hours please attend A&E. In an immediate emergency call 999 or attend A&E.*

For any questions or queries please call Solar’s Duty Line on 0121 301 2750.

**If you have any difficulties in completing this form or need any other languages please call 0121 301 2750 to speak to our Duty Worker whom can assist.**

***Please note Solar do not offer assessments for Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Specific Learning Difficulties such as Dyslexia, Dyspraxia etc. For these please seek referrals to;***

* ASD - Specialist Assessment Service;

[Specialist Assessment Service – Solihull Children's Community Therapies (uhb.nhs.uk)](https://childrenscommunitytherapies.uhb.nhs.uk/specialist-assessment-service/)

**0121 722 8010**

* **ADHD – Solihull Community Paediatrician referral via your GP**
* **Specific Learning Difficulties – please discuss with your Education Setting.**

Please provide as much detail as possible in this form, to enable the referral to be comprehensively triaged and without delay. **Incomplete forms or forms lacking relevant information will be returned to referrers for completion.**

**About Data and Information (Privacy Notice)**

Our full privacy notice is on our website: [www.bsmhft.nhs.uk/our-services/solar-youth-services/](http://www.bsmhft.nhs.uk/our-services/solar-youth-services/). By completing this form and sending it to us you understand the child’s and your personal data will be stored to provide a service in the public interest.

Solar takes it's responsibility to safeguard every person seriously; if we have concerns we will always endeavour to discuss these with you first, however there may be some occasions where we need to share information with relevant parties to ensure children, young people and their families are safeguarded.

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| **Referral Form PART A:** All Referrers to Complete |
| Date of Referral:  |
| **CHILD/YOUNG PERSON’S (CYP) DETAILS** |
| Preferred Pronoun(s):  |  | Date of Birth:  |
| Forename:  |  | Surname:  |
| Preferred Name:  |  | Sex assigned at birth:  |
| Ethnic Origin:  |  | Gender identity: |
|  1st Language:  | Interpreter Needed? Yes / No |
| NHS No: |  |
| School: Is this school under our Mental Health Support Team (MHST)? Yes / No / Don’t Know |
| GP Practice: |  |
|  Home Address: Postcode:  |  |
| Child/Young Person Phone: | Child/Young Person Email Address: |
| Parent/Carer Phone:  |  Parent/Carer Email Address: |
| **GP DETAILS** |
|  Name: | GP Practice: |
| GP Practice Address: Postcode: |
|  Phone No: | Email Address: |
| **PARENTAL RESPONSIBILITY** [inc. Local Authority if applicable](*Please include all person(s) regardless of whether they live in the same household*) |
| Parent/Carer Full Name: Parent/Carer Date of Birth:  | Parent/Carer Full Name: Parent/Carer Date of Birth:  |
| Address: Postcode:  |  | Address: Postcode: |
|  Relationship to CYP:  | Relationship to CYP: |
|  1st Language:  Interpreter Needed? Yes / No | 1st Language:Interpreter Needed? Yes / No |
| Support needs (e.g. mental health, physical health, access, interpreter, filling in forms): | Support needs (e.g. mental health, physical health, access, interpreter, filling in forms): |
| Is this Child/Young Person currently on a Child in Need or a Child Protection plan? Yes / NoIf yes, please detail allocated Social Worker:  |
|  Is the Child/Young Person Adopted? Yes / No | Date of Adoption:  |
| Is the Child/Young Person a Young Carer or has caring responsibilities? Yes / No |
| **LOOKED AFTER CHILDREN/YOUNG PERSON(S) (LAC) ONLY** **If LAC, the CYP’s allocated Social Worker’s details must be completed before the referral is processed.****For LAC Children and Young People Part B of referral form must be completed in addition** |
|  Is the child Looked After under the Children’s Act? Yes / No*If Yes:*  Placing Authority:  CYP’s Legal Status:Interim Care Order: Yes / No Full Care Order: Yes / No Special Guardianship Order: Yes / No |
|  Name of allocated Social Worker:  |
| Team:  |
| Address:Postcode:  |
| Phone No: | Email: |
| **REFERRER’S DETAILS** |
|  Referral Source: *Please Tick*

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| Self Referral |  | GP |  | School |  |
| Community Paediatrician |  | LD Nurses |  | Children’s Services |  |
| School Nurses |  | Other (Please Specify): |  |

  If you are a Social Worker seeking LATCH/LAC Consultation please complete Referral Form Part B (in addition to Part A). |
|  Name: | Job Title/Profession: |
|  Organisation:  | Relationship to CYP: |
| Address: Postcode: |
|  Phone No: | Email: |
| **CHILD/YOUNG PERSON’S (CYP) SPECIALIST NEEDS** |
| Does the CYP have a formal diagnosis of Autism Spectrum Disorder/Condition (ASD/ASC)? | Yes / No | If yes, please provide details of date of diagnosis and any current support: |
| Does the CYP have a formal diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)? | Yes / No | If yes, please provide details of date of diagnosis and any current support: |
| Does the CYP have a diagnosed learning difficulty ie. dyslexia, dyspraxia etc | Yes / No  | If yes, please provide details of date of diagnosis and any current support: |
| Does the CYP have a diagnosed learning disability? | Yes / No |  If yes, please provide details of date of diagnosis and any current support:Are they on GP Learning Disability Register? Yes / No |
| Does the CYP have any physical health diagnoses/conditions?  | Yes / No |  If yes, please provide details of date of diagnosis and any current support: |
| Does the CYP have any suspected diagnoses/conditions? | Yes / No |  If yes, has the CYP been referred for assessment/support? |
| **OTHERS SUPPORTING THE CHILD/YOUNG PERSON AND FAMILY** |
| **Agency/Service** | **Current or Historic Involvement (*where possible provide dates*)** | **Details of Named Person/Contact Details** |
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| **CONSENT** |
| Does the Child/Young Person know about and consent to the referral? Yes / No | *If answered no, please give reason:**(The voice of the child is incredibly important to Solar. Where possible we strongly encourage consent to be gained from children and young people for their referral*.) |
| Do all listed Parent/Carers know about and consent to the referral? Yes / No | *If answered no, please give reason:* |
| Does the Child/Young Person consent to the parent/Carer being contacted?  Yes / No | *If answered no, please give reason and provide details re who to contact and how:* |
| Does the Child/Young Person’s School know about the referral? Yes / No | *If answered no, please give reason:* |
| **REASON FOR REFERRAL***(Please detail mental health/emotional wellbeing concerns including severity/frequency/length of time over which they have been presenting/impact on the CYP’s daily life)****Please note if we do note have enough information/detail this could cause delays in processing/accepting referrals.***  |
| *Please provide more information below, you may want to think about:** *How the child/young person knows they are having difficulties, what are their thoughts, emotions, behaviours or physical feelings?*
* *What triggered / contributed to these difficulties? When did they start?*
* *What keeps the problems going and means they keep feeling/thinking that way?*
* *What is going well for them? What helps them to feel better*
* *What previous/current support has been received for the CYP’s mental health/emotional wellbeing?*
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| **WHAT SUPPORT IS THE CHILD/YOUNG PERSON WANTING?** |
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| **WHAT SUPPORT IS THE PARENT/CARER/REFERRER WANTING?** |
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| **RISK/SAFEGUARDING***(Please note this Section MUST be completed and details of safety plans/actions must be listed.)*  |
| If you believe a Child or Young Person is in Crisis (including suicidal thoughts with intent/plans/attempts) please seek urgent help by calling **0121 262 5500 (**8am-8pm). For out of hours please attend A&E. **In an immediate emergency call 999 or attend A&E.**Please note that if a child/young person is at risk of significant harm from others, to others or to themselves you must report this as a Child Protection Concern via your local Multi-Agency Safeguarding Hub (MASH) or follow Crisis advice above before submission of referral.  |
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| **Risk Factors** | **Risk Level***(Please circle/highlight)* | **Further Info/Details:***(Please include how risk is being managed currently)* |
| Self-Harm (inc. risk of self-neglect) | NoneYes – CurrentYes – Historic | *Please note if medical attention has been needed/sought, frequency and severity* |
| Suicidal Thoughts | NoneYes – CurrentYes – Historic | *Please note intensity of thoughts, any intent, any plans, any historic attempts* |
| Harm from Others | NoneYes – CurrentYes – Historic |  |
| Harm to Others | NoneYes – CurrentYes – Historic |  |
| Parental/Sibling/Family with Mental Health | NoneYes – CurrentYes – Historic |  |
| Child Exploitation | NoneYes – CurrentYes – Historic |  |
| Risk relating to eating *(e.g diet restriction, purging etc.)* | NoneYes – CurrentYes – Historic | *Please note any concerning weight loss (including height and current weight), fainting episodes, associated physical health concerns, repeated vomiting episodes* |
| **Referral Form PART B:** Please complete for Looked After Children/Young People (LAC) Only |
| **WHAT SUPPORT IS NEEDED?** *(Identify as many as needed)* |
| Professional Support: Yes / No | Detail: *(Please note if you are in need of Specialist Consultation to inform practive we may not see the child directly)* |
| Parent/Carer Support: Yes / No | Detail: |
| One-to-one support for the CYP: Yes / No  | Detail: |
| **LEGAL STATUS** |
| **I**nterim Care Order: Yes / No | Section 20: Yes / No |
| Full Care Order: Yes / No | Other: |
| Placing Authority:  |
| Date CYP was accommodated:  |
| **PLACEMENT DETAILS** |
| Type of Placement *(Please tick)*:

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| --- | --- | --- | --- |
| Short term foster care |  | Long term foster care |  |
| Bridging Placement |  | Connected carers  |  |
| Placement with Parent/s |  | Residential Care |  |
| Other *(please specify)*:  |  |

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| Name of Foster Carer: Is this foster carer a Local Authority Foster Carer: Yes / NoIndependent fostering agency: Yes / No |
| Supervising Social Worker: Local Authority: Yes / No Private Agency: Yes / NoName: Address: Contact No: Email:  |
| Independent Reviewing Officer: Name: Address: Contact No: Email:  |
| Allocated Children in Care Nurse: Name: Address: Contact No: Email:  |
| Has life story work been completed? Yes / No*If so please provide brief detail including dates.*  |
| Are the following documents attached? *(Please tick)***NB: The following must be attached to support the child/young person’s referral.**

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| Chronology |  | Genogram |  |
| Last LAC Review |  | Last LAC Review Health Assessment |  |
| Recently scored SDQ |  |  |  |

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