**Mental Health Support Team**

**Request For Help Form**

Please complete this form with the child or young person you are requesting support for, giving as much detailed information as possible. The more information we have the easier it is to process the request. If you would like to discuss the child or young person with one of the team before submitting the referral, please contact us on 01823 368481.

**Please send completed referral form to:**

[**spn-tr.MHSTSomerset@nhs.net**](mailto:spn-tr.MHSTSomerset@nhs.net)

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| **Child/Young Person Details** | | | | | | | |
| **Forename** |  | | | **Surname** |  | | |
| **Preferred name** |  | | | **Date of Birth** |  | | |
| **Home Address Postcode** |  | | | **GP Practice** |  | | |
| **NHS Number** |  | | | **Ethnicity** |  | | |
| **EAL**   * 1. *If yes, first language*   2. *Interrupter required?* |  | | | **Year Group** |  | | |
| **Attendance %** |  | | |
| **Gender** |  | | |
| **Is the child in the Looked After Children system** | | | | |  | | |
| **Does the child have any communication barriers?** *If yes, please give details* | | | |  | | | |
| **Complete this section if young person aged 13-16 and Fraser competent or 16+**  *A young person between 13 and 16 can be considered Fraser competent if they have the understanding to be capable of making a reasonable assessment of the advantages and disadvantages of the proposed therapy***.** | | | | | | | |
| **Has the young person given consent for parent/ guardian to be contacted?** *Yes / No* | | | | | |  | |
| **How would the young person like to be contacted?** *Complete all of those appropriate* | | | | | | | |
| **Text-** *mobile number* | |  | | | | | |
| **Phone call-** *telephone number* | |  | | | | | |
| **Email address** | |  | | | | | |
| **Is parent / guardian aware of the request?** *Yes or No* | | | | | | |  |
| **I consent to this request being made**  *Young person’s signature* | | |  | | | | |
| **Do you consent to sessions being recorded for training, assessment and quality assurance?** *Yes or No* | | | | | | |  |

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| **Child’s/Young Person’s Current Difficulties** | | | |
|  | | | |
| **Child’s/Young Person’s view -***in their own words* | | | |
|  | | | |
| **Any significant life events/changes** *e.g. parental separation, transitions* | | | |
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| **Relevant past experience of mental health difficulties** | | | |
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| **Current or past history of self-injury?** *If yes, give details (severity, duration…)* | | | |
|  | | | |
| **Current or past history of harm to others?** | | | |
|  | | | |
| **Previous psychological therapy/treatment** | | | |
|  | | | |
| **End date of most recent treatment** *(if known)* | | | |
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| **Current or previous school based support** *Has C/YP been referred to the school nurse?**Have they had or having PFSA or ELSA support/ PRU outreach or targeted or additional support?* | | | |
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| **Any other information or comments** | | | |
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| **Has this young person previously requested support from the Mental Health Support Team?** *If yes please supply date and intervention* | | | |
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| **Has the child/young person been to TAC/TAS?** *If yes, please attach an electronic copy of the school action plan.* | | |  |
| **Early Help Assessment completed?** *Electronic copy attached Yes/ No* | | |  |
| **Contact Details of statutory/voluntary organization currently/previously involved** | | | |
| **Name and Agency**  **Contact Number**  **Email** | |  | |
| **Name and Agency**  **Contact Number**  **Email** | |  | |
|  | | | |
| **Referrer Details** | | | |
| **Referrers Name** |  | | |
| **Job Title** |  | | |
| **School** |  | | |
| **Email Address** |  | | |
| **Direct Dial** |  | | |
| **Date of request** |  | | |
| **Signature of referrer** |  | | |

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| **Parent/Guardian Contact Details** | | | | | | | | | | | |
| **Title** |  | **Forename** | |  | | **Surname** | | |  | | |
| **Landline number** | | |  | | **Mobile number** | | |  | | | |
| **Email Address** | | | |  | | | | | | | |
| **Do you consent to sessions being recorded for training, assessment and quality assurance?** *Yes / No* | | | | | | | | | | |  |
| **GDPR and Data consent are required for the request to be accepted.** | | | | | | | | | | | |
| All personal data will be processed by Young Somerset (YS) and Somerset NHS Foundation Trust in accordance with the Data Protection Act 1998 & 2018 General Data Protection Regulation and in accordance with Young Somerset’s and Somerset Partnership NHS Foundation Trust Data Protection Policy and Guidelines. YS and Somerset Partnership NHS Foundation Trust collect this data/information for the following purposes:   * Running and evaluating activities, including contacting you when necessary. * Internal purposes such as auditing, evaluation, data analysis, preventing or detecting fraud or error, and research to improve our service and customer communications. * For funder/commissioners’ purposes on reporting who has benefited from working with YS. * Medical information will be shared if this information protects the health and well-being of your son/daughter.   YS and Somerset NHS Foundation Trust collect this data in the following way:   * Consent forms, Registers, Session Evaluation Forms, Incident Forms, Surveys and Outcomes. * YS and Somerset NHS Foundation Trust store this data securely both with hard and electronic forms. * YS and Somerset NHS Foundation Trust will not hold your personal data for longer than is necessary (max of 3 years) for the above purposes. We will not share your personal data with third parties, unless legally required to do so. If you have any questions about our data protection policy / procedures, please contact us. Somerset NHS Foundation Trust will hold relevant and pertinent information on the trusts patient electronic records system.   The Data controller for YS is: James Brookes, Project Manager for Young Somerset – contact [jamesbrookes@youngsomerset.org.uk](mailto:jamesbrookes@youngsomerset.org.uk)  Data Controller for Somerset Partnership NHS foundation trust is: Louise Coppin, data protection officer – contact [Louise.Coppin@tst.nhs.uk](mailto:Louise.Coppin@tst.nhs.uk)  Somerset County council will share information from educational psychology and public health nursing where this information will enable staff to make recommendations around the type of support required.  **I the undersigned have read the information about Data Protection, and agree to my child’s personal data being used in the way described above.** | | | | | | | | | | | |
| Print Name | |  | | | | | | | | | |
| Signature | |  | | | | | Date | | |  | |