**Mental Health Support Team**

**Request for Help Form**

**Please complete this form with the child or young person you are requesting support for and try to complete all sections 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: spn-tr.MHSTSomerset@nhs.net

|  |  |
| --- | --- |
| **Name of child or young person:**  | **Requesters name/role:** **Contact number:**  |
| **Date of birth:**  |
| **Gender (if prefer not to disclose – leave blank):****Ethnicity:**  | **School details:** |
| **NHS number (on sims):** | **Year group:****Attendance %:** |
| **Child or Young Person’s Address:** **Home Tel:** **Mobile:** **Is young person ok for us to leave a message:** **Home: Y/N Mobile: Y/N Text: Y/N** | **GP Name:** **GP Practice:** **Address:** **Phone number:** **Email:**   |
| **Email:** | **Preferred way for us get in contact with you:** |
| **Parent/Carer Name:** | **Parent/carer telephone number:** |
| **Is Parent/Carer aware of request?**  **Y/N** | **If Fraser competent (*or over 16*) has the young person given consent for parent /carer to be contacted? \* Y/N**  |
| **First Language** |  | **Interpreter required:** | Yes | No | **If yes, which language / dialect:** |
| **Does the child have any communication barriers?** | Yes | No | **If yes, please give details:** |
| **Is the child in the Looked After Children system?****If child is Looked After, request must be received from the allocated Social Worker** | Yes | No | **If yes, please give details:** |
| **Contact details of any other statutory or voluntary organisation currently or previously involved:**  |
| **Name and Agency** |  |
| **Contact number** |  |
| **Email:** | **Preferred way for us get in contact with you:** |
| **This section must be completed**I consent to this request being made Young person’s signature: Verbal consent given by parentI understand that if another agency is deemed as more appropriate the child or young person will be referred by the MHST  **Agree/Disagree** | **Signature of person making this request:** |
| **Date of request:**Does the young person or parent consent to sessions being recorded for training, assessment and quality assurance **YES NO** |
| *\*A young person under 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.* |
| **Please provide as much information as possible.****Current difficulties** (please provide as much detail as possible and include mental health difficulties and how they impact school or home) **What is the CYP view** (in their own words)**Any significant life events/changes? E.g. parental separation, transitions** **Relevant past experience of mental health difficulties:****Current or past history of self-injury?** Yes / NoIf yes, please give details (severity, duration…)**Current or past history of harm to others?** Yes / No**Previous psychological therapy/treatment**: **End date of most recent treatment (if known):** **Previous school based support:**Has CYP been referred to the school nurse? Have they had PFSA support?Have they had ELSA support?PRU outreach?*Has this young person previously requested support from the Mental Health Support Team?* Yes No  |
| **What are you hoping to achieve from this request for Help?****What would you like to see happen?****Has child/young person been to TAC/TAS, if so when? What is the school plan?****Any other information or comments:** |

**Data protection statement:**

**All personal data will be processed by Young Somerset (YS) and Somerset Partnership NHS Foundation Trust (SOMPAR) 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 SOMPAR 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 SOMPAR collect this data in the following way:
Consent forms, Registers, Session Evaluation Forms, Incident Forms, Surveys and Outcomes.
YS and SOMPAR store this data securely both with hard and electronic forms.

YS and SOMPAR 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. SOMPAR 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

Data Controller for Somerset Partnership NHS foundation trust is: Louise Coppin, data protection officer – contact Louise.Coppin@tst.nhs.uk

**Data Consent:** *Please tick appropriate box in agreement with this statement:*

I have read the information about Data Protection, and agree to my son’s/daughter’s personal data being used in the way described above:

 **YES** □ **NO** □Signature………………………………………………. Date…………………………….