**Mental Health Support Team**

**Request For Help Form**

* Only referrals made by professionals can be accepted.
* Requests from schools must come via the School’s Mental Health Lead.
* Please do complete this form with the child or young person you are requesting support for.
* Please do give as much detailed information as possible to assist our assessment of needs. 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 do provide full contact details for parent/guardian and child so that we may easily get in touch.

**How we use your/your child’s data**

All personal data will be processed by Young Somerset (YS) and Somerset NHS Foundation Trust in accordance with the Data Protection Act 2018 General Data Protection Regulation and in accordance with Young Somerset’s and Somerset NHS Foundation Trust Data Protection Policy and Guidelines. Young Somerset and Somerset 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 Young Somerset.
* Medical information will be shared if this information protects the health and well-being of your son/daughter.

Young Somerset and Somerset NHS Foundation Trust collect this data in the following way:

* Consent forms, Registers, Session Evaluation Forms, Incident Forms, Surveys and Outcomes.
* Young Somerset and Somerset NHS Foundation Trust store this data securely both with hard and electronic forms.
* Young Somerset 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.

Data Controller for Young Somerset is: James Brookes, Project Manager for Young Somerset contact [jamesbrookes@youngsomerset.org.uk](mailto:jamesbrookes@youngsomerset.org.uk) Head of Information Governance and Data Protection Officer for Somerset NHS Foundation Trust contact [Louise.Coppin@SomersetFT.nhs.uk](mailto:Louise.Coppin@SomersetFT.nhs.uk)

Somerset County Council will share information from educational psychology, Children’s Social Care and public health nursing where this information will enable staff to make recommendations around the type of support required.

Data will be shared with internal or external agents including the University of Exeter for service improvement purposes and wider publication.

**Please send completed referral form to:** [**spn-tr.MHSTSomerset@nhs.net**](mailto:spn-tr.MHSTSomerset@nhs.net)

**Section 1 - Personal Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 a Looked After Child (LAC)** | | | | | | | | | | | | |  | | | |
| **Does the child have any communication barriers?** *If yes, please give details* | | | | | | | | | |  | | | | | | |
| **Young Person’s contact details and consent**  **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***.** | | | | | | | | | | | | | | | | |
| Sessions are recorded for training, assessment and quality assurance | | | | | | | | | | | | | | | | |
| **Is parent/guardian aware of this Request?** | | | | | | | | | | | | | | | *Yes / No* | |
| **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** | | | | | |  | | | | | | | | | | |
| **I consent to this request being made**  *Young person’s signature* | | | | | | | | |  | | | | | | | |
| Do you agree to take part in future participation activity such as feedback or service development? | | | | | | | | | | | | | | | | Yes/No |
| **Parent/Guardian Contact Details** | | | | | | | | | | | | | | | | |
| **Title** |  | | **First name** | | | | |  | | | | **Last name** | | | |  |
| Landline number | | | | |  | | | | | | Mobile number | | |  | | |
| Email address | |  | | | | | | | | | | | | | | |
| **I consent to this request being made**  *Parent/Guardian signature* | | | | | | |  | | | | | | | | | |
| Sessions are recorded for training, assessment and quality assurance | | | | | | | | | | | | | | | |  |
| Do you agree to take part in future participation activity such as feedback or service development? | | | | | | | | | | | | | | | | Yes / No |

**`Section 2 – Description of current difficulties**

|  |  |  |  |
| --- | --- | --- | --- |
| **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* | | | |
|  | | | |
| **Relevant past experience of mental health difficulties** | | | |
|  | | | |
| **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)* | | | |
|  | | | |
| **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?* | | | |
|  | | | |
| **Any other information or comments** | | | |
|  | | | |
| **Has this young person previously requested support from the Mental Health Support Team?** *If yes please supply date and intervention* | | | |
|  | | | |
| **Has the child/young person been to TAC/TAS?** *Yes/ No*  *If yes, please attach an electronic copy of the school action plan.* | | |  |
| **Early Help Assessment completed?** *Yes/ No*  *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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