

Protocol & Form to for request an out of area Child and Adolescent Mental Health Service (CAMHS) for use by Social Workers (version 2)

1.1 Criteria for referral:

- The Child or Young Person is Looked After by Hertfordshire County Council but resides and is registered with a GP outside of Hertfordshire.
- The responsible worker is able to demonstrate that the needs of the child or young person cannot be met by Hertfordshire CAMHS; therefore a referral to the local CAMHS service to where the Child or Young Person resides and is registered with a GP is required.

1.2 Exclusions

This form is solely for **planned CAMHS** community interventions:

- Inpatient mental health services are funded by NHS England Midlands and East regional team, CPC1, Victoria House Capital Park, Fulbourn, Cambridge, CB21 5XE 0113 825 5320 england.ppnf-eaat@nhs.net and are referred to by specialist CAMHS.
- Emergency treatment should be accessed without delay using the care pathways local to the placement e.g. A&E

1.3 Conditions of referral:

- The referring social worker will maintain contact with the service provision and attend CAMHS Assessments and meetings as appropriate.
- The allocated social worker/team will make sure the Out of Area CAMHS Service completes a transfer into Hertfordshire should the Child Young Person return and still require ongoing treatment.
- SDQ's are completed and scored.

1.4 Further treatment:

- Authorisation relates solely to the funding purpose outlined. If further treatment is required or if an assessment results in a request for a treatment intervention: The treatment plan and cost will need to be forwarded for further funding agreement.
- There will be a need to demonstrate that local services remain unable to meet the needs of the young person locally.

1.5 Authorisation Process

You will be contacted by telephone or email if further information is required. Confirmation of funding authorisation will be issued within five days of receipt of this form by the Commissioning Team.

Forms should be sent to:

email - camhs.commissioning@hertfordshire.gov.uk

All communications containing patient identifiable information should be password protected and sent via secure email.



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OUT OF COUNTY CAMHS FUNDING FORM

1. CHILD/YOUNG PERSON'S DETAILS

Child/Young Person's Name	
Date of Birth	
NHS Number	
Date Entered Care (Current Episode)	
Registered General Practice at time of entering care & CCG and NHS Number if known	
Current Registered General Practice (GP) & CCG if known.	
Current placement full address and telephone numbers	

2. REFERRER'S DETAILS

Name of Referrer	
Team/Service	
Contact Email	
Contact telephone Number	

3. PREVIOUS INTERVENTIONS

Please use this section to outline what has been delivered to date:

Intervention Delivered & Outcome	By Whom	When? (+ Length)

4. REFERRAL DETAILS

Please complete or provide the referral letter ensuring the areas below are covered.

Service Being Requested (Organisation/Trust and Department)	
Reason for referral to CAMHS	
Strengths & Difficulties Questionnaire (SDQ's) Scores (please include completed SDQ's)	
Cost (If known)	
Detail the specific factors, complexities and risks requiring assessment/intervention	
What are the proposed outcomes?	

FORM COMPLETED BY:

Name:
Job Title:
Signature:
Date:

CONSENT to referral agreed by:

Name(s):
Designation
Signature:
Date:

AUTHORISATION

To be completed by Social Worker/Team Manager/Service Manager

SDQ's completed scored and enclosed: Yes/No – (Please note this is required)

Name: Job Title:

Signature: Date:

To be completed by Commissioners:

Date Submitted:

Commissioning Responsibility: E&N Herts CCG/ HV CCG/ IHCCT

Outcome: Funding Approved/ Not Approved (If yes outline any conditions/ if no give reasons)

Unique Funding Reference:

Name: Job Title:

Signature: Date:

Please note this form is not a referral; please include this form with your referral letter to the local CAMHS service so that they have the invoicing details and Unique Funding Reference.