**GROWING TOGETHER REFERRAL FORM**

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| **PLEASE NOTE YOU ARE REFERRING TO A SERVICE WHICH IS A PARTNERSHIP BETWEEN ISLINGTON PRIMARY CARE ADULT MENTAL HEALTH SERVICES (iCope) AND ISLINGTON CAMHS EARLY YEARS SERVICE.  WE ARE NOT AN EMERGENCY SERVICE. IF THERE IS SIGNIFICANT OR IMMEDIATE RISK PLEASE REFER TO EMERGENCY OR CRISIS SERVICES. FOR ANY CONCERN ABOUT A CHILD PLEASE REFER TO CHILDRENS SOCIAL CARE.**  **Kindly fill in ALL mandatory (\*) fields below to help us process your referral quicker. Incomplete referrals will be returned to the referrer which might result to delays. If you are unsure whether a referral is appropriate at this time or if you would like to discuss a potential referral, please call 020 3316 1824 or email** [**growingtogether@nhs.net**](about:blank) **(for use by referrers only) to arrange a consultation with one of our clinicians. You can also use the flowchart at the end of this document to inform your decision. For more information about Growing Together, visit:** [https://bit.ly/3oLQuAI](about:blank) ***Thank you for considering our service.*** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*Referred Parent/Carer 1 (please complete all information):** | | | | | | | | |
| **\*NAME:** | . | **\*DOB:** | . | | | **\*NHS no:** | | . |
| **\*ADDRESS:** | . | **\*CONTACT NUMBER:** | | | . | | | |
| **\*EMAIL:** | | . | | | | |
| **\*Is an interpreter needed?** | . | **\*ETHNICITY:** | | . | | | | |
| **\*Specify what language** | . | **\*FIRST LANGUAGE:** | | . | | | | |
| **\*Are they open to any other mental health services?**  *We cannot accept the referral if the parent is currently using another mental health service.* | | | | | | | . | |
| **\*Is the referred parent registered with an Islington GP?** We cannot accept referrals if the parent is registered with a non-Islington GP | | | | | | | . | |
| **\*Are you referring this parent to our service?**  *Please only refer parent(s) with mental health difficulties.* | | | | | | | . | |
| **\*Has the parent consented to the referral?**  *We cannot accept the referral without the parent’s consent.* | | | | | | | . | |

**PLEASE EMAIL YOUR COMPLETED FORM TO:** [**growingtogether@nhs.net**](about:blank)

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|  | | | | **\*DATE:** **.** |
| PROFESSIONAL OR SELF REFERRAL?  ***If you are a referring professional, please fill in your details in the box below.*** | | . | | |
| Growing Together Clinician completing the self-referral with the parent  ***If self-referral, the GT clinician to complete this section*** | | . | | |
|  | | | | |
| **\*REFERRERING PROFESSIONAL’S NAME:** | . | **ADDRESS:** | . | |
| **\*JOB TITLE AND ORGANISATION:** | . | **\*WORK PHONE NUMBER:** | . | |
| **\*EMAIL:** | . | |

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| **Parent/Carer 2: (including step-parents)-please complete all information below only if you are referring both parents:** | | | | | | | | |
| **\*NAME:** | . | **\*DOB:** | . | | | **\*NHS no:** | | . |
| **\*ADDRESS:** | . | **\*CONTACT NUMBER:** | | | . | | | |
| **\*EMAIL:** | | . | | | | |
| **\*Is an interpreter needed?** | . | **\*ETHNICITY:** | | . | | | | |
| **\*Specify what language:** | . | **\*FIRST LANGUAGE:** | | . | | | | |
| **\*Are they open to any other mental health services?**  *We cannot accept the referral if the parent is currently using another mental health service.* | | | | | | | . | |
| **\*Is the referred parent registered with an Islington GP?** We cannot accept referrals if the parent is registered with a non-Islington GP | | | | | | | . | |
| **\*Are you referring this parent to our service?**  *Please only refer parent(s) with mental health difficulties.* | | | | | | | . | |
| **\*Has the parent consented to the referral?**  *We cannot accept the referral without the parent’s consent.* | | | | | | | . | |

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| **\*Referred child/children aged 1-5** | | | | | | | | | |
| **\*CHILD’S NAME:** | | **\*DOB:** | | **NHS no:** | | **\*CHILD’S ETHNICITY** | | | **\*CHILD’S FIRST LANGUAGE** |
| . | | . | | . | | . | | | . |
| . | | . | | . | | . | | | . |
| . | | . | | . | | . | | | . |
| . | | . | | . | | . | | | . |
|  | | | | | | | | | |
| **Any other children/members of the household:** | | | | | | | | | |
| **NAME** | | | **DOB/AGE** | | | | **RELATIONSHIP TO REFERRED CHILD/PARENT** | | |
| . | | | . | | | | . | | |
| . | | | . | | | | . | | |
| . | | | . | | | | . | | |
| . | | | . | | | | . | | |
|  | | | | | | | | | |
| **Professionals involved with the family:** | | | | | | | | | |
| **\*ISLINGTON GP Name:** | | | | | ADDRESS: | | | . | |
| PHONE: | . | | | | EMAIL: | | | . | |
| **HEALTH VISITING TEAM:** | | | | | ADDRESS: | | | . | |
| PHONE: | . | | | | EMAIL: | | | . | |
| **SOCIAL WORKER:** | | | | | ADDRESS: | | | . | |
| PHONE: | . | | | | EMAIL: | | | . | |
| **FAMILY SUPPORT PRACTITIONER:** | | | | | ADDRESS: | | | . | |
| PHONE: | . | | | | EMAIL: | | | . | |
| **ANY OTHER SERVICES INVOLVED:** | | | | | ADDRESS: | | | . | |
| PHONE: | . | | | | EMAIL: | | | . | |
| **\*REASONS FOR REFERRAL** *(Note:* ***both*** *parent(s) and child(ren) need to be presenting with difficulties for a referral to be accepted)* | | | | | | | | | |
| **\*Please give a brief description of the referred parent’s mental health/ psychological difficulties:**  *(note these would need to be mild-moderate, primary care level for a referral to be accepted)* | | | | | | | | | |
| . | | | | | | | | | |
| **\*Please describe the difficulties the referred child/ren (aged 1-5) is/are presenting with:**  *(e.g. seems withdrawn, sad or anxious; shows aggressive, hyperactive or repetitive behaviours; has difficulties with separation, sleep, toileting, feeding or in their relationship with their parent/s)* | | | | | | | | | |
| . | | | | | | | | | |
| **\*Are there any risk issues, e.g. risk of suicide/self-harm/physical aggression, vulnerability, self-neglect and/or concerns about the child/ren’s wellbeing and safety?** | | | | | | | | | |
| . | | | | | | | | | |
| **\*How are the risks currently being managed?** | | | | | | | | | |
| . | | | | | | | | | |
| **\*How did you hear about our service? Please select the answer that applies most** | | | | | | | | | |
| . | | | | | | | | | |
| **If other, please state how:** | | | | | | | | | |
| . | | | | | | | | | |
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| Is there anything else you would like us to know for the referred family? | | | | | | | | | |
| . | | | | | | | | | |

**We have the following interventions available:   
*(please note that the actual option offered will be based upon our clinical assessment)***

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| **Workshops (2 hours, daytime – no referral needed)**  - Mindfulness and Parenting Workshop  -Calmer Nights Sleep Workshop  Parents can sign up to our workshops via our Eventbrite page: [*https://www.eventbrite.co.uk/o/growing-together-13053709783*](about:blank)  **MindSkills group**  A course for parents to learn CBT skills to manage depression or anxiety  **Mellow Parenting Group** A parenting group for mothers with children aged  1-5 years old. | **Adult psychological therapies**  **Parent-infant/child psychotherapy**  **Family/co-parenting couples therapy**  **Child behaviour management and parenting advice** |
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**Growing Together referral criteria:**Summary Flowchart

