**Text

Description automatically generated with low confidence**

**Branching Minds Barnsley request for support form**

Branching Minds Barnsley brings together mental health support teams (MHST) and child and adolescent mental health services (CAMHS) under one roof; helping local children, young people and their families get the right support at the right time.

Branching Minds Barnsley takes requests for support directly from professionals, parents, carers and young people. A child or young person must be registered with a GP practice in Barnsley to request support from the service.

The MHST can help with a wide range of mild and moderate mental health and emotional wellbeing issues, whilst CAMHS can provide further specialist support.

To request support, please complete this form and return it to the Branching Minds Barnsley team via email on: [BarnsleyCYPMHRequestSupport@swyt.nhs.uk](mailto:BarnsleyCYPMHRequestSupport@swyt.nhs.uk)

You can also call the team on 01226 107377, Monday – Thursday, 9am to 5pm and Friday, 9am to 4pm (excluding bank holidays), to discuss a request for support.

Your request for support will be reviewed in partnership by the Branching Minds Barnsley team to help make sure you receive the most appropriate support.

|  |  |
| --- | --- |
| **About the child or young person who is requesting support** | |
| Name: |  |
| Also known as: |  |
| Date of birth: |  |
| Gender: |  |
| Preferred pronoun: |  |
| NHS number: |  |
| Home address: | |
| Contact number/s: |  |
| Ethnicity: |  |
| Main language spoken: |  |
| Does the child or young person have any communication needs or accessibility requirements? E.g., sign language, easy read, wheelchair access: | |
| Is an interpreter required if the child or young person’s first language isn’t English? | Yes ☐ No ☐ |
| Religion: |  |
| Does the child or young person consent to this request for support? | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Information about the parent or carer of the child or young person** | | |
| Name: | |  |
| Relationship to child or young person: | |  |
| Does the parent or carer consent to this request for support? \*  \* If a young person is completing this request for support themselves, then a parent or carer will only be informed of this if there is a safeguarding risk or concern. | | Yes  No |
| Postal address (if different from the child or young person’s address): | | |
| Phone number(s): |  | |
| Email address(es): |  | |
| Is an interpreter required if the parent or carer’s first language isn’t English? | | Yes  No |
| Preferred method of contact: Post ☐ Telephone ☐ Email ☐ | | |
| Does the parent or carer have any communication needs or accessibility requirements? E.g., sign language, easy read, wheelchair access: | | |

|  |  |
| --- | --- |
| **Information about the child or young person’s GP practice** | |
| GP name: |  |
| GP surgery name and address: | |
| Contact number/s: |  |
| **Height and weight information – for eating disorder support requests only**  If requesting support around eating disorders and problems, a child or young person must have height and weight measurements recorded by a healthcare professional within the last seven days. Please provide height and weight recordings and date(s) taken along with the contact details of the healthcare professional which recorded these – this could be a GP, school nurse or hospital practitioner. Please also provide any previous height and weight recordings if known. | |
| Height: | |
| Weight: | |
| Date taken: | |

|  |  |
| --- | --- |
| **Information about the person making this request for support** | |
| Name: |  |
| Relationship to child or young person: |  |
| Organisation (if applicable): |  |
| Address: | |
| Your contact phone number: |  |
| Your email address (if applicable): |  |
| When did you last see the child or young person? (if applicable) |  |

|  |  |
| --- | --- |
| **School or college information** (if applicable) | |
| Name of the school or college that child or young person attends: |  |
| Year group: |  |
| Name of key contact/member of staff at school or college: |  |
| Telephone number of the school or college: |  |

|  |  |
| --- | --- |
| **Does the child or young person have any additional needs?** | |
| Early help assessment | Yes  No  I don’t know |
| Open to team around the family or child in need | Yes  No  I don’t know |
| Subject to a child protection plan (CPP) | Yes  No  I don’t know |
| Elected home educated (EHE) | Yes  No  I don’t know |
| Looked after child or care leaver | Yes  No  I don’t know |
| Young carer | Yes  No  I don’t know |
| Excluded from school or college/at risk of exclusion | Yes  No  I don’t know |
| Substance misuse e.g., alcohol or drugs | Yes  No  I don’t know |
| Not in education, employment or training (NEET) | Yes  No  I don’t know |
| Special educational need or disability (SEND) | Yes  No  I don’t know |
| Physical health needs (including allergies) | Yes  No  I don’t know |
| Any existing diagnosis (e.g., ASD, ADHD, PTSD, OCD, anxiety, depression) | Yes  No  I don’t know |
| Education Health and Care Plan (EHCP) | Yes  No  I don’t know |
| Please provide more details: | |

|  |
| --- |
| **What are the main problems that the child or young person would like help with? And how is this affecting their life?** |
| Please provide more information here and tick any of the below which are relevant. |
| Low mood: sadness, low motivation  Mild to moderate anxiety: worries, fears and concerns |
| Common challenging behaviours; angry outbursts, pushing boundaries  Difficulty managing emotions  Family, friends and overall relationship difficulties  Difficulty adjusting to change and/or transition |

|  |
| --- |
| **What are the children or young person’s goals?**  **What is the parent or carer’s goals?**  **What is the professional’s or referrer’s goals? (If making this referral)**  E.g., Think about the reason for the referral, how are they feeling or behaving at home or school? What is worrying you or the child or young person? How can Branching Minds Barnsley provide help and support? What benefits do you want to see from making this request for support? |
|  |

|  |
| --- |
| **What other agencies or services are supporting the child, young person or their family?**  E.g., social care, family support worker, pastoral school support |
|  |

|  |
| --- |
| **Are there any current or previous risks to the child or young person?**  E.g., please include risks of harm to self or others, any safeguarding concerns  \*For professionals; please attached any current or previous risk assessment, if applicable |
|  |

|  |
| --- |
| **Has the child or young person had any past or current significant medical conditions?**  E.g. any allergies, long-term conditions or hospital treatment or stays |
|  |

|  |
| --- |
| **Privacy notice, consent and information sharing** |
| **Please tick the statement(s) which applies to you:**  I am making this request for myself or my child. I understand that information provided to the service will be stored securely and electronically and shared between CAMHS, MHST my GP and any other agency where it is necessary to safeguard me or provide me with appropriate support:  The request for support has been discussed with the child or young person and they have capacity and have consented to the referral. I have explained that the information will be stored securely electronically and may be shared between CAMHS, MHST, their GP and any other agency where it is necessary to safeguard or provide the appropriate support:  I am making this request for a child or young person who does not have capacity to give informed consent. I have discussed this with the parent/carer and explained that the information will be stored securely and electronically and may be shared between CAMHS, MHST, their GP and any other agency where it is necessary to safeguard or provide the appropriate support: |