**Kirklees CAMHS Specialist Learning Disability Service**

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| **Please note currently we are only accepting referrals for children or young people who are attending the following Specialist Education Provisions, Castle Hill School, Fairfield School, Ravenshall School including PFA, Southgate School, Woodley School, and College. Referrals can be made by child/young person, parents/carer, or any other professional.**  There are two entry pathways to request support for children who **DO NOT** attend one of the five special schools please see:   * Kirklees Keep in Mind visit <https://kirklees-keep-in-mind.nhs.uk/>   Schools can request a school consultation via Kirklees Keep in Mind.   * [Mental health support for children and young people | Kirklees Council](https://www.kirklees.gov.uk/beta/mental-health/mental-health-support-children-young-people.aspx) |

**Who do the Kirklees CAMHS Learning Disability Service work with?**

Our Specialist Community Learning Disability Service accept referrals regarding children and young people with a significant learning disability who are:

* Up to 18 years of age
* Resident in Kirklees or registered with a **Kirklees GP**
* Attends one of the schools mentioned above.
* In relation to the current referral need, they have been unable to have their **mental health and/or physical health needs** met through **mainstream service provision** after applying reasonable adjustment principles.
* The presence of behaviours that challenges, where the behaviour is of severity and frequency to cause **significant** risk to self, others, or the environment, or lead to restrictive practice, exclusion, or significantly impact on the child or young person’s quality of life.

**The completed form to be sent to**: [camhsneuro@swyt.nhs.uk](mailto:camhsneuro@swyt.nhs.uk)

We encourage referrers to contact the team on **01484 343184** to ask for a consultation if you are unsure, we are the right service for the child or young person. Admin will take your details and you will receive a call back within five working days.

Referrals are discussed on a weekly basis and the referrer will be noticed of the decision via a letter.

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| Kirklees CAMHS Learning Disability Service referral form **please complete all sections**:  Please complete all sections in the referral form. Where there is not enough information provided, we may need to return the form to the referrer for more information.  Please provide enough information to help us understand why involvement of a Specialist Learning Disability Service is needed.  Please attach letters, documents, and any reports where these can help us assess for eligibility to access a Specialist Learning Disability Service and what Mental Health concerns there currently are for the child/young person.   |  | | --- | | 1. **Consent: The Specialist Learning Disability Team are unable to progress this referral without consent.** | | **Child under the age of 16:**  Has the parent/carer provided informed consent for this referral? YES / NO  ***or***  **Young person aged 16 or over:**  Does the young person have capacity to consent to this referral? YES / NO  If NO, has a mental capacity assessment and subsequent best interests’ decision been made for this referral? YES / NO  Are all the relevant members of the child/young persons’ current network aware of this referral to the Team? YES / NO   |  |  | | --- | --- | | Name: | Agency/name of Organisation: | | Role/position: | Date of referral made: | | Address: | Post Code: | | Email address: | Contact No: |  1. **Details of person making referral – This section must be competed in full.** | |  | | | |
| |  |  | | --- | --- | | First Name: | Surname (family name): | | Preferred Name: | Any other names previously used: | | NHS No (if known): |  | | DOB: | Religion: | | Gender: | Preferred Language:  Interpreter required? Please specify language: | | Ethnicity: | Religion: | | Parents/Carers Name (S):  Address if different from child/young person | GP Name:  GP Address:  Phone Number: | | Child/young person’s Address:  Post Code: | Contact Number:  Email Address: | | School/College:  Address: | Education contact: | | Previous CAMHS involvement YES / NO  If yes provide details: |  | | Diagnosis/health needs: | Current medication: |  1. **Personal information.** | | |
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| 1. **Referral Information.** | |
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