Mental Health
Integrated Access Partnership
Intelligent Mental Health System Response

Integrated Access Partnership (IAP) to AWP Trusted Assessment Pathways (BNSSG)

Standard Operating Procedure

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Standard Operating Procedure (SOP)

Introduction

This Standard Operating Procedure (SOP) provides detail on the Trusted Assessment Pathway (TAP) from all Integrated Access Partnership (IAP) services into Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) community services in Bristol, North Somerset & South Gloucestershire (BNSSG).

The tables below outline the IAP (referrer) and AWP services (accepting service) included within this SOP.

IAP Services Included (referrer)
Mental Health Specialist Desk (999)
Mental Health Response Vehicle
Mental Health Clinical Assessment Service (111)

AWP Community Services Included (accepting service)
Bristol Single Point of Access
North Somerset PCLS
South Gloucestershire PCLS
All Bristol Crisis teams (North & West, Inner City & East and South)
North Somerset Intensive Team
South Gloucestershire Intensive Team
All Bristol Assessment & Recovery Teams (North & West, Inner City & East and South)
North Somerset Recovery Team
South Gloucestershire Recovery Team (North & South)
BNSSG CAMHS Getting Advice Service
BNSSG Crisis Intervention and Outreach Team (CIOT)
SIFT Self-harm Peer Support

Purpose

The purpose of this SOP is to outline the TAP between the IAP and AWP services to ensure that service users do not have to tell their story to different clinicians or services multiple times; therefore, supporting that once an assessment has taken place, referrals are accepted which reduce duplication of work and delays to receiving ongoing treatment and interventions.

Objectives

The objectives of this SOP are:

- To describe a clear and agreed process between IAP and AWP community services (adult and children and young people) for onward treatment and intervention where clinically appropriate without delay
- To ensure that the local specifications of AWP services are considered and understood in support of onward referrals from IAP services
- To ensure efficient and effective use of IAP and AWP resources through reduction in unnecessary duplication of assessment process

Trusted Assessments

To qualify as a trusted assessment, IAP clinicians should ensure:

- The reason for the referral is specific, with a clear action or request for the receiving team
- That consent is given by the service user*

** Should the person not consent to a referral but there is sufficient concern, the IAP clinician may attempt to facilitate a referral to provide more assertive follow up, or to prompt further liaison.*

Assessments can only be considered 'trusted' if sufficient information has been gathered and documented. If the IAP clinician is unable to carry out a full assessment, this should be made clear in the referral (with detail of why this was not possible) with a clear ask that the receiving team complete a full assessment.

IAP Service Overview

The IAP is an all-age service which delivers a range of services through 111 and 999, supporting individuals with an emergency or urgent mental health need. All IAP services provide screening, triage and assessment service responses, therefore onward intervention and treatment is provided by a range of mental and physical healthcare providers including AWP.

AWP Community Service Overview (Adult Services)

Primary Care Liaison Services/Bristol Single Point of Access

Service	Telephone Number	Opening Times
Bristol Triage (SPA)	0117 919 5670	08:00 – 22:00
North Somerset PCLS	01934 836406	08:00 – 18:00
South Gloucestershire PCLS	0117 378 7960	08:00 – 17:30

Service Overview	Key Service Information
The Primary Care Liaison Service (PCLS) provides a first point of contact for adults to access secondary mental health services. In Bristol, this service is known as Bristol Mental Health Single Point of Access (SPA). Referrals are made from primary care, other healthcare professionals and self-referral (rarely). Core interventions are telephone triage; face-to-face assessment; brief interventions; support, advice and signposting.	• Enable concurrent management of referrals with other agencies/referrers where clinical risk or need indicates this, e.g. referrals that may require a physical health review by GP will still be processed by PCLS where risk to self may indicate need • Act as a locality-based, extended hours, point of access for adults into local secondary adult mental health services • Provide digital and in person assessments, ensuring that face to face assessment is offered where clinically indicated • Ensure that service users are only transferred to secondary mental health services where there is an assessed need for that service • Liaise with local community mental health teams to ensure a smooth transfer for those service users who are assessed as requiring a standard package of secondary care.

	• Work closely with the relevant local authority and partners to provide as seamless a health and social care service as possible.

Crisis and Intensive Teams

Crisis/Intensive Team	Telephone Number	Opening Times	
Bristol Crisis Team (Central)	0117 354 7257	08:00 – 22:00	The three areas merge and jointly cover the whole BNSSG patch overnight (22:00 – 08:00)
Bristol Crisis Team (North)	0117 354 6606		
Bristol Crisis Team (South)	01275 796209		
North Somerset Intensive Team	01934 836497		
South Gloucestershire Intensive Team	0117 378 4250		

Service Overview	Key Service Information
Adult Intensive Services offer rapid assessment and treatment for people who are experiencing a mental health crisis. In South Gloucestershire and North Somerset these teams are known as Intensive Support Teams. In Bristol, the Intensive Service is known as Bristol Crisis with three teams available in the city: Central, North and South. Each team provides proactive and intensive support to avoid the symptoms of a mental health emergency getting worse. The aim of these services is to offer treatment and care in an individual's own home as an alternative to hospital admission.	• Provide urgent face to face assessments within 4 & 72 hours of accepting a referral. • Available to individuals aged 18 and over • Remain involved until the crisis resolves, usually up to 4 to 6 weeks. Shorter term episodes of care are common. • Provide a coordinating role around the use of acute inpatient services, including assessing along with a Care Co-ordinator from recovery services, the need for acute ward admission, aims and predicted length of stay

Recovery and Assessment & Recovery Teams

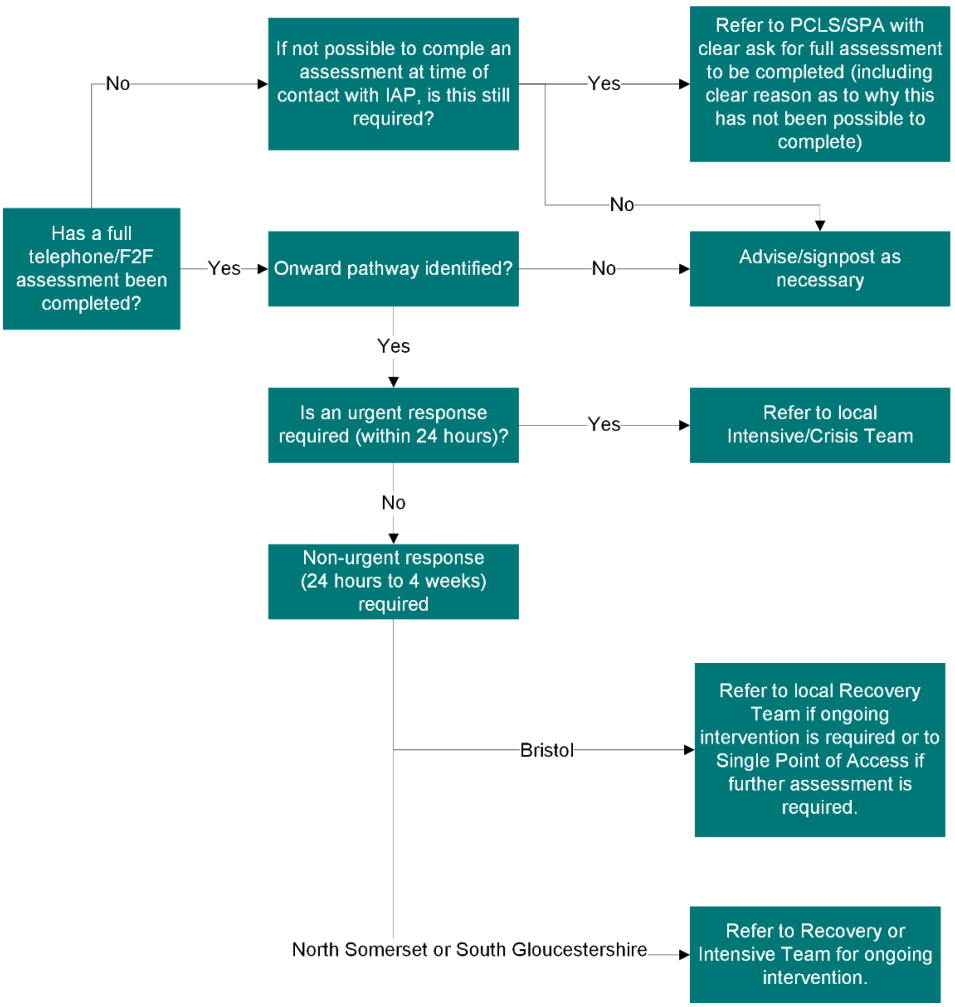
Recovery Team	Telephone Numbers	Opening Times
Bristol Recovery Team (Central)	0117 955 6098	09:00 – 17:00 (Mon – Sun)
Bristol Recovery Team (North)	0117 354 7327	
Bristol Recovery Team (South)	01275 796200	
North Somerset Recovery Team	01934 523700	09:00 – 17:00 (Mon – Fri)
South Gloucestershire Recovery Team (North)	01454 271000	
South Gloucestershire Recovery Team (South)	0117 378 4611 / 4621	

Service Overview	Key Service Information
Recovery teams operate in Bristol, North Somerset and South Gloucestershire. In Bristol, the Recovery Service is known as Assessment and	• Recovery teams carry out assessments, develop an individual care plan, risk management plan and crisis plan to support a service users journeys through mental health services • Recovery teams work closely with GPs, community

Recovery, with three teams available in the city: Central, North and South. Each team provides care, treatment and support to adults with severe and enduring mental health conditions, including mood disorders, anxiety disorders, psychosis, and personality disorders.	services, third sector, psychiatric hospitals, and other service providers. Assigned Care Coordinators may provide direct interventions or link people with other services for support • Recovery teams treat service users from the age of 18 to end of life in the community who suffer from serious mental illness where interventions delivered in primary care have failed, or where the level of complexity requires management under the care programme approach (CPA) • Recovery teams must maintain a steady rate of transition back to primary care when initial recovery goals have been achieved due to demand on these services

Trusted Assessment Process

The below diagram shows the agreed process for IAP services to follow when considering a referral to an AWP community team:



Service-Specific Referral Information

The table below outlines the service-specific key referral information to consider when referring to AWAP community teams:

Triage Teams
• Referrals from IAP to PCLS / Bristol SPA will be made only in exceptional circumstances. This is because IAP and PCLS provide similar assessment functions and can facilitate the same routes into relevant services. • IAP staff will always attempt to complete a telephone assessment of the individual in need of mental health support. Where this is not possible, i.e. due to partial or disrupted engagement; concerns which cannot be satisfied over the telephone; or where the acuity of the incident is particularly high • IAP clinicians will attempt to dispatch a Mental Health Response Vehicle to the scene of an incident. If these interventions cannot be provided, and all other options have been exhausted, IAP clinicians may make a referral for further triage / assessment with the relevant PCLS team. • Prior to referral it's important to confirm whether the individual is under another secondary care team, and that they do not already have an assessment booked with another AWP service. In this event, contact should first be made with that service. • Consent from the individual is required for the referral to take place. • Where Sequoia is identified as the most appropriate pathway, we can refer to PCLS who will make this referral on our behalf (until such time that IAP can refer directly to Sequoia) • Please refer to Appendix 1 for referral paperwork
Crisis/Intensive Teams
• All referrals must be made over the telephone and discussed with a registered member of the Crisis/ Intensive team • Crisis/ Intensive team services require that a clear plan/request for the crisis intervention is identified prior to the referral • **Email referrals are not accepted** • Refer to Appendix 2 for a list of questions that the crisis team practitioner would want covered as part of the IAP assessment. Where possible, these should be addressed in the IAP assessment template and documented on RiO
Recovery Teams
• Prior to referral, telephone contact and discussion should be held with the Duty Practitioner or a Senior Practitioner • Out of hours, telephone calls must be made to the appropriate alternative team, see details below • When discussing an onward referral with a service user, it should be made clear that the Recovery Team is not an 'emergency service' and that contact will be made as soon as possible- this may be up to four weeks following referral. It must also be made clear that acceptance of the referral is not guaranteed. • Refer to Appendix 3 for a list of questions that the Recovery Team practitioner would want covered as part of the IAP assessment. Where possible, these should be addressed in the IAP assessment template and documented on RiO • Following a discussion, a Care Pathway Referral Form (Appendix 4) must be completed and emailed to the appropriate address. The form must outline relevant background information and expectation of referral, i.e. further assessment and / or a direct allocation for care coordination. The referral email addresses are identified at the top of the Care Pathway Referral Form

IAP to AWP Trusted Assessment Pathway
Standard Operating Procedure (SOP)
BNSSG AWP Children & Young People Mental Health Service (CAMHS)

The IAP supports children and young people (CYP) as well as their parents/carers and professionals, via NHS111 (option 2) and 999 in Bristol, North Somerset & South Gloucestershire. They provide timely triage, risk assessment, advice, de-escalation and onward care, ensuring the most appropriate response and onward pathway.

The information below sets out the agreed processes for CYP calls into the IAP within BNSSG, where an onward referral into CAMHS is required.

NB: This SOP is delivered alongside the Overarching IAP SOP (please refer to these documents for further details around clinical recording, training, etc.).

Referrals

Following triage and assessment, if an urgent or routine referral is required to be made to the AWP CAMHS service (for individuals not currently within CAMHS services) the practitioner must refer to the CAMHS Getting Advice Service (GA), ensuring the following:

- Verbal consent obtained for referral to be made
- If suspected eating disorder, then IAP clinician should also encourage the patient to book a GP appointment for physical monitoring
- If unsure if the patient requires CAMHS referral, IAP can call GA professional line 0117 340 8570 in office hours
- IAP clinician makes referral using CAMHS Referral form (see Appendix Five) and email to: awp.camhscommunityreferrals@nhs.net

Should upon receipt and review of the referral from the IAP, the Getting Advice Service do not feel that the referral is appropriate or should circumstances change, they will make contact with the patient directly to inform them of this and offer additional signposting/resourcing as appropriate. The IAP will not be copied into this outcome letter. Any inappropriate referrals will be monitored as part of ongoing collaboration with CAMHS.

Notification of Contact

IAP contacts regarding CYP who are open to CAMHS, or regarding CYP who are not currently open and require routine or urgent follow-up from CAMHS teams, must be shared with CAMHS for their awareness. This includes where a referral is being made, and for contact with a CYP currently on their caseload.

This notification must be emailed to awp.admingettingadvice@nhs.net with the following details:

- Patient name
- IAPTUS number
- Patient date of birth
- Whether or not the patient is currently open to CAMHS
- Urgency of action:
    - For information only (only for patients currently open to CAMHS)
    - Routine
    - Urgent

All clinical contacts with children & young people in BNSSG to be added onto IAPTUS by the practitioner (in line with the IAP Overarching SOP).

IAP to AWP Trusted Assessment Pathway
Standard Operating Procedure (SOP)

SIFT Self-Harm Peer Support Service

Service Overview

The SIFT Self Harm Peer Support service is a peer-delivered, non-medical, non-judgmental support service delivered by people with their own experience of self-harm. The team work with individuals to help them understand their self-harm and how best to manage it.

Referral Criteria

- Age 18 and over
- Resident in BNSSG
- Are not at high risk of suicide or significant self-harm (green and amber on metric scale are suitable and if the patient can wait up to 3 working days to be contacted)
- Not already on caseload of secondary care or being referred to PCLS
- People who have accessed an IAP service
- Not accessed the service within the last 6 months (ask the patient; could also check Connecting Care). It's OK to re-refer if they did not ever manage to engage with the SIFT Peer Support service. If the patient has engaged with the service in the last 6 months, SIFT team will contact the patient to inform them they are not suitable. See SIFT Team responsibilities below
- The person is affected by self-harm. This covers all forms of self-harm (e.g. cutting, overdoses where patient is unsure of intent, risk-taking, self-neglect etc) – if in doubt, email the team

Service offer

- Patients referred to The SIFT service will be contacted within 3 working days
- Where accepted into the service, patients will be offered a 90-minute support appointment within 2 weeks, either face to face or via videocall or phone. The service also provides relevant resources and put the person in touch with any services that were discussed
- A 45-minute follow-up appointment then offered after 2 weeks of initial support appointment to check in and see if any extra support or resources are needed

SIFT service responsibilities

As the IAP is not a case-holding service; if the patient is not suitable for the service i.e. doesn't meet the criteria or has engaged with the service in the last 6 months, it has been agreed that the SIFT team will contact the patient to inform them and provide a discharge letter outlining other options for support and signposting.

At point of discharge, SIFT team will write a letter to patients GP informing them of contact with the service.

How to refer

IAP practitioners should complete the following referral form: SIFT Referral form

If you have questions about suitability, you can contact the team by emailing bnssg.selfinjurysupport@nhs.net

Escalation of Referrals into AWP

Where the TAP has been followed but there remains concerns regarding the onward pathway for a service user, the IAP worker should escalate concerns or issues to the IAP Clinical Navigator (IAP CN) or a senior clinician within the IAP. The IAP CN can then liaise directly with the accepting team leads such as the Senior Practitioner or Team Manager. If the accepting team believes the referral does not meet their thresholds for acceptance the following steps must be taken:

- A collaborative discussion must occur to agree on an alternative treatment route
- If no alternative route is available, the receiving service must accept the referral and log an incident report to support service learning and quality improvement.

Monitoring of SOP Impact

The TAP SOP will be monitored through IAP service line dashboards, continued engagement with AWP community services and any relevant incident reports. Both the IAP and AWP will work together to continually improve the response through the urgent and emergency care pathway for service users who require ongoing treatment and intervention.

Monitoring & Change Register

The IAP SOP will be reviewed at least annually and more regularly to account for service changes and expansion.

Date	Version	Author	Change
12/12/2025	1.0	Caryss Knighton	New SOP. V1.0 published. This SOP supersedes *AWP trusted assessment pathways from Emergency Service Triage* guidance document [archived: MH IAP Shared Space/Governance/SOPs/Trusted Assessment SOP/Archive]
29/06/2026	1.1	Caryss Knighton	Correction to telephone number for Bristol Crisis (North) Added AWP CAMHS referrals in line with ERL closure Added SIFT Self-Harm Peer Support Service
30/06/2026	1.2	Ollie Crandon	Amended AWP CAMHS referrals in line with ERL closure

Appendix 1: BNSSG PCLS/Bristol SPA Referral Form for Follow-Up Assessments

Avon and Wiltshire Mental Health Partnership NHS Trust

PCLS (TRIAGE) REFERRAL FORM

PLEASE NOTE: NO FAX REFERRALS WILL BE ACCEPTED BY THE PCLS (TRIAGE) SERVICE

Urgency of assessment

Please indicate the urgency of this referral, i.e. how quickly do you feel that the patient needs contact from the service.

This is based on your clinical judgement and risk assessment. However, following triage by a Mental Health professional the timeframe to assessment may be amended in line with the UK Triage Scale. You will be notified of referral outcome by letter or email, following triage.

We will attempt to make contact within 72 hours unless the assessment is urgent. Please ensure that the patient's contact details are up to date and please make them aware that we will call from a withheld number.

Emergency/4 hour referrals

For emergency/4 hour referrals, please contact your local PCLS service using the numbers below.

BSW	BNSSG
Banes: 01225 371480	Bristol (Triage Team): 0117 919 5670
Swindon: 01793 835787	North Somerset: 01934 836406
Wiltshire: 01722 820372 (South)/01380 737840 (North)	South Gloucestershire: 0117 3787960

Urgent/routine referrals:

☐ **Within 72 hours**	☐ **Within 4 weeks**
Urgent mental health response	Routine mental health response
Please complete and submit this referral form to PCLS and then contact your local PCLS service using the numbers above.	Please complete and submit this referral form to PCLS.

Is this patient known to AWP services or was discharged from services within the last 3 months?
Yes ☐ No ☐

Patient details [*details pulled directly from your clinical system*]				Referrer details	
Full Name:		**Preferred name:**		**Date of referral:**	
Gender:		**D.O.B:**		**Referring GP:**	
NHS No:		**Marital status:**		**Registered GP name & address:**	
Address:		**Postcode:**		**Referring GP telephone no:**	
Home Tel No:		**Mobile Tel No:**		**Ethnicity:**	
Religion/Belief:		**Main language:**		**Interpreter required?**	

Pregnancy and maternity	**Is the patient pregnant?** **Yes ☐ No ☐ Not applicable ☐**
Disability	**Does the patient consider themselves to be disabled? Yes ☐ No ☐** *A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.* **☐ Physical/Mobility (e.g. difficulty walking, climbing stairs, lifting & carrying objects)** **☐ Vision (e.g. due to blindness or partial sight)** **☐ Hearing (e.g. due to deafness or partial hearing)** **☐ Learning or concentrating or remembering** **☐ Social or behavioural (e.g. due to neuro diverse conditions such as Autism, Attention Deficit Disorder or Asperger's Syndrome)** **☐ Other impairment** **Please expand, as necessary:**
Gender reassignment	**Has the patient gone through any part of a process, or do they intend to (including thoughts and actions) to bring their physical sex appearance, and/or gender role, more in line with their gender identity?** ***This could include changing their name, appearance, the way they dress, taking hormones or having gender confirming surgery*** **☐ Yes ☐ No** **Male/female assessor preference**

	☐ **Male** ☐ **Female**
Sexual Orientation	**Which of the following best describes the patient's sexual orientation?** ☐ **Heterosexual/straight** ☐ **Bisexual** ☐ **Lesbian** ☐ **Gay** ☐ **Other**
Carer Details	
Other Patient Contacts	**Is there anyone (family/friend/others) that is providing support/involved in the care of this individual?**

Name	**Telephone Number**	**Relationship**

Consent:	**Has your patient consented to a referral to this Service?** **Yes** ☐ **No** ☐ **If the patient does not consent to a referral, or you have concerns regarding capacity please specify the reason below:**

Reason for referral – Referrals may be rejected without this information
Please provide a narrative of your concerns about this patient's mental state to include why he/she requires secondary mental health services and what you require from our assessment. Please also indicate what interventions you have tried in primary care prior to making this referral e.g. talking therapies, social prescribing, medication:

Risk to self and others
Please ensure you answer all of the following for the safety of patient, staff and the public

	Yes	No	Not known
1. Is this person expressing thoughts of suicide or self-harm?	☐	☐	☐
If the answer to the above question was yes, please provide details			
2. Has the person ever made a suicide or self-harm attempt?	☐	☐	☐
If the answer to the above question was yes, please provide details			

3. Is the person expressing thoughts or has previously engaged in episodes of violence/aggression?	☐	☐	☐
If the answer to the above question was yes, please provide details			
4. Is the home environment safe to visit?	☐	☐	☐
If the answer to the above question was yes, please provide details There has been no expressed thoughts to harm others just feeling low			
5. Is there concern about harm or exploitation from others e.g. domestic violence, sexual harassment or abuse, financial abuse?	☐	☐	☐
If the answer to the above question was yes, please provide details			
6. Are there any child protection/safeguarding issues?	☐	☐	☐
If the answer to the above question was yes, please provide details			
7. Does the patient have any dependents/children/vulnerable adults/pets?	☐	☐	☐
If the answer to the above question was yes, please provide details			
8. Is the person at risk of self-neglect, physically or emotionally?	☐	☐	☐
If the answer to the above question was yes, please provide details			
9. Is there concern about the person's general current behaviour e.g. risk taking, sleep pattern, activities of daily living?	☐	☐I	☐
If the answer to the above question was yes, please provide details			
10. Is there a history of misusing drugs or alcohol?	☐	☐	☐
If the answer to the above question was yes, please provide details None spoken about today			
11.Is there a history of depression or serious mental illness, including any current episode?	☐	☐	☐
If the answer to the above question was yes, please provide details			
12.Does the person have a shotgun/firearm licence?	☐	☐	☐
If the answer to the above question was yes, please provide details Not disclosed			

Patient Consultations [Please upload latest results directly from GP system]
Please provide last few consultations, wherever possible
Patient Problems [Please upload latest results directly from GP system]
Current medication being prescribed at date of referral [Please upload latest results directly from GP system]

Confirmed allergies at date of referral [Please upload latest results directly from GP system]
Recent diagnostics [Please upload latest results directly from GP system]

Appendix 2: Crisis/Intensive Team Referral Checklist

IAP clinician to consider the following questions before making the referral.

Establishing answers to these questions will aid the trusted referral process and also help to manage the service users' expectations around this onward pathway. Answers to these questions should be explored as part of your assessment and included in your clinical records.

Referrals should be made via a telephone call to the Crisis Team.

1	Has the service user consented to the referral being made?
2	Is the service user willing to meet at the IST base if appropriate?
3	Is the service user willing to meet face to face for an initial assessment, preferably at home or another appropriate location?
4	Has the service user been seen face to face (today)?
5	Has the referrer explored other means of supporting the service user? If so, what?
6	What would the intervention be from IST/ what is the purpose of this referral?
7	What does the referrer feel should happen if the service user does not answer calls/ contact?
8	Is the service user aware that if we do not gain contact we will be assertive, and act as deemed appropriate to ensure they are safe? e.g. Cold call and if no answer, welfare check where their door/property could be forcibly entered to ensure they are safe.
9	What are the risks to others from the service user? (these must be explored and documented, with plan to mitigate)
10	When was the last face to face assessment? Does this require a 4 hour referral or 72 hour?

Appendix 3: Recovery Team Referral Checklist

IAP clinician to consider the following questions before making the referral.

Establishing answers to these questions will aid the trusted referral process and also help to manage the service users' expectations around this onward pathway. Answers to these questions should be explored as part of your assessment and included in your clinical records.

1	Has the service user consented to the referral being made?
2	Is the service user willing to meet at the Recovery base if appropriate?
3	Is the service user willing to meet face to face for an initial assessment, preferably at home or another appropriate location?
4	Has the referrer explored other means of supporting the service user? If so, what?
5	What would the intervention be from Recovery/ what is the purpose of this referral?
	Are they willing to engage in longer term work with this team if this is identified as an appropriate intervention?
6	What does the referrer feel should happen if the service user does not answer calls/ contact?
7	What are the risks to others from the service user? (these must be explored and documented, with plan to mitigate)
8	Are there any physical health considerations? E.g. alcohol/ drugs/ infections
9	Are there any factors we need to be aware of in terms of how we assess/ support this individual? E.g. learning disability, language barriers etc.
10	Does this person have a formal diagnosis?

Appendix 4: Recovery Team Referral Form

CARE PATHWAYS REFERRAL

awp.NorthCarePathways@nhs.net
awp.BristolCentralCarePathways@nhs.net
awp.PethertonCarePathways@nhs.net
awp.NorthSomersetRecoveryTeam@nhs.net
awp.SouthGlosRecoveryReferrals@nhs.net

NAME OF CLIENT		**Date of Birth**		**Ethnicity**	
ADDRESS		**GP**			
RIO NUMBER		**NHS NO**			
To be Completed by REFERRER					
REQUEST					
COMMENTS					
Documents attached					

To be Completed by ICPA Coordinator			
DATE RECEIVED			
MEETING DATE			
RIO Number		**NHS Number**	

REFERRAL DETAILS	**REFERRAL FROM:**	
	REFERRAL TO :	

To be Completed by Receiving Team Manager	
REFERRAL ACKNOWLEDGED ? (Letter sent out to referrer acknowledging that the referral has been received and dealt with)	**COMMENTS**

Appendix 5: AWP BNSSG CAMHS Referral Form

Community Children's Health Partnership

NHS Avon and Wiltshire Mental Health Partnership NHS Trust

Child and Adolescent Mental Health Services (CAMHS) referral form
Bristol, North Somerset & South Gloucestershire

When completed please return to: awp.camhscommunityreferrals@nhs.net

Please note: Completion of all fields is mandatory. Incomplete or incorrect forms (including incorrect versions) will be returned, which will delay the referral process.
Before completing or submitting the referral please check eligibility and referral criteria for each service (www.awp.nhs.uk/camhs/professionals).

<table>
<tr><td colspan="3">Nature of Referral: Urgent ☐ Routine ☐</td></tr>
<tr><td>Child/Young Person's Surname:</td><td>Forename/s:</td><td>Date of Birth:</td></tr>
<tr><td colspan="2">NHS No:</td><td>Gender:</td></tr>
<tr><td colspan="3">Ethnic Category – please choose one option that best describes the child/young person's ethnic group or background:</td></tr>
<tr><td colspan="2">White:
English/Welsh/Scottish/Northern Irish/ British ☐
Irish ☐
Gypsy or Irish Traveller ☐
Roma ☐
Any other white background, please describe……</td><td>Black/African/Caribbean/Black British:
African ☐
Caribbean
Any other Black/African/Caribbean ☐background, please describe……..</td></tr>
<tr><td colspan="2">Asian/Asian British:
Indian ☐
Pakistani ☐
Bangladeshi ☐
Chinese ☐
Any other Asian background, please describe……..</td><td>Mixed/Multiple Ethnic Groups:
White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any other Mixed/Multiple ethnic background, please describe……..</td></tr>
<tr><td colspan="2">Other Ethnic group:
Arab ☐
Any other Ethnic group, please describe……..</td><td>Not stated ☐</td></tr>
<tr><td colspan="2">Home address:

Postcode:

Home telephone number:

Mobile number:

Email address:</td><td>Name of main carer:

Relationship to Child:

Who has parental responsibility? (please list)
Name and address (if different from the child or young person)
1.

2.</td></tr>
</table>

	Has a person with parental responsibility agreed to this referral: Yes ☐ No ☐
School/Nursery/Preschool name and address:	Child/Young Person's GP Name and Address: Has GP been informed? Yes ☐ No ☐
Child's first language …….. Carers' first language …… Is an interpreter or signer required? Yes/No (please indicate) If yes the service required……... Can parents/carers access written information? Yes/No (please indicate)	Is this child/young person a Child Looked After? Yes ☐ No ☐ Unknown ☐ Is this child/young person subject to a Child Protection Plan? Yes ☐ No ☐ Unknown ☐
To ensure we communicate effectively and efficiently with our parents/carers/ young people, we often use digital methods of communication for appointment booking & reminders, appointment letters, requisition of questionnaires or other documents, signposting to relevant resources, requests to contact the service where action is required and for friends & family feedback surveys. Does the person with parental responsibility give consent for us to contact them for the above purposes by: (Our primary, agreed method is by post and phone call). Text Yes ☐ No ☐ Email Yes ☐ No ☐ Information Sharing: Does the person with legal responsibility consent to information sharing? (See website for further details) Yes ☐ No ☐ It is important to ensure that the parent/carer is aware that the information detailed in referrals made to CAMHS may be shared with other health professionals and external agencies who are closely associated with health professionals, such as education or social services. More information is available at www.connectingcarebnssg.co.uk	

Referred by: (Please note - The fields below MUST be completed to enable us to process the referral)
I confirm that a person with parental responsibility has given their consent for this referral and for appropriate services to be allocated.

Referred by (name): …… Date: ……

Role: ……

Address:
……

Telephone number (s): …… Email address: ……....

Reason for referral: (Please include the mental health difficulty and what support is required from CAMHS)

Please explain the impact of this problem on the child/young person's daily life: (Please include impact on eating, sleeping, education, home and social life)

Please outline any strategies that have been used to help the child/young person and whether these have been successful: (eg. School counselling, how many sessions and the nature of the work eg. CBT based etc)

Relevant History including key areas of concern

(e.g. Education, Medical, developmental issues, family structure)

Which other professionals are already involved with this child/young person?

Name	Service	Address

NB: Clinical staff will consider whether the child will need to be seen by one service, a combination of services or a more appropriate service than the one referred to. The decision will be based on the information you provide. The outcome will be included in your acknowledgement letter.

AWP Child and Adolescent Local Community Mental Health Service (CAMHS) ☐ Please note: required additional information forms **If you are making a referral for an Eating Disorder service** please complete the CAMHS Eating Disorder Service form Care Pathway (Remedy BNSSG ICB)	**AWP CAMHS Asylum Seeker and Refugee Clinic (ARC)** ☐ Works with children and young people who are experiencing post-traumatic stress disorder (PTSD) symptoms. The service support Children and young people who either are in the UK with their family, or who have arrived in the UK unaccompanied, without a carer or family. (see website for further details) Please note: required additional information forms Asylum & Refugee Clinic (ARC) (Remedy BNSSG ICB)
AWP Child and Adolescent Mental Health Service for Learning Disability (CAMHS-LD) **Bristol and South Gloucestershire** ☐ **North Somerset** ☐ (See Website for further details and referral criteria)	**AWP CAMHS Be Safe** ☐ Works with Children and young people who have engaged in problematic/harmful sexual behaviour and their support network (See website for further details) Please note: Be Safe uses a specific referral form which is available on website along with the Service's Referral Criteria. The service would ask that potential referrers make a referral enquiry call to Be Safe prior to submitting a referral.
AWP Children in Care and Adoption Services (see website for further details) Thinking Allowed Bristol ☐ Thinking Aloud South Gloucestershire ☐	**AWP CAMHS Young Peoples Specialist Substance Misuse Service** (see website for further details) ☐