



Hillingdon Mental Health Support Team

Working with schools to provide specialist support for children, young people & families with mental health challenges at an early stage

Guided Self-Help: *Secondary School Self-Referral Form*

Who We Are

Mental Health Support Teams (MHSTs) primary goals include offering evidence-based interventions for children and adolescents with mild to moderate mental health concerns, to aid in their education. The service is active in various schools in Hillingdon and aims to enhance mental health assistance for the youth. **Please note we are only able to offer support to students attending the schools listed in the following form.**

What We Do

We provide both individual and group interventions with a focus on low intensity, effective methods for children, adolescents, and their families facing the following challenges:

- **Adolescent Anxiety:** Addressing worries, nervousness, and panic attacks. Learn techniques to manage anxiety, reduce worry, and confront fears.
- **Adolescent Low mood:** Supporting those feeling down and lacking motivation. Understand low mood, engage in valued activities, and manage negative thoughts.

How to Refer

To self-refer for MHST support, please edit the digital fillable PDF referral form, save the document & return via email to: adminhillingdoncamhsmhst@nhs.net or have a look at our website cnwl.nhs.uk/services/mental-health-services/child-and-adolescent-mental-health-services/mental-health-support-team-schools-mhst

What Happens After You Make a Referral?

Once we have received your referral, we will respond via email or a send a letter to your address to acknowledge that we have received it. We will aim to do this within a week. Our clinicians will then discuss your referral as a team and agree on the next steps.

Further Support

Support with risk or complex issues falls outside of our remit. However, if you need help urgently please:

- Call the Mental Health Urgent Advice Crisis Line on **0800 023 4650** for advice and support from a mental health professional via telephone. The crisis line is open 24/7, including weekdays, weekends and bank holidays.
- Make an urgent appointment with your GP.
- In a non-emergency, call **111** and select the mental health option if you feel distressed or worried about your mental health
- Attend Accident & Emergency only if the young person or others are in immediate danger or crisis.
- In an emergency, dial **999** or attend the Accident & Emergency department at your local hospital.

*Please note that if children and young people that are referred to us do not meet the criteria, our MHST will do its best to provide advice and signposting information.

Referrer Details

Name of person making the referral		Relationship to the young person <i>(Only referrals with parental consent will be accepted)</i>	
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Child's School

<input type="checkbox"/> Barnhill Secondary	<input type="checkbox"/> Park Academy
<input type="checkbox"/> Bishopshalt Secondary	<input type="checkbox"/> Parkside Academy
<input type="checkbox"/> De Sallis Studio	<input type="checkbox"/> Queensmead Secondary
<input type="checkbox"/> Douay Martyrs Secondary	<input type="checkbox"/> Rosedale College
<input type="checkbox"/> Harefield School	<input type="checkbox"/> Ruislip High School
<input type="checkbox"/> Harlington School	<input type="checkbox"/> Swakeley's School for Girls
<input type="checkbox"/> Haydon School	<input type="checkbox"/> The Skills Hub
<input type="checkbox"/> Hewens College	<input type="checkbox"/> UTC Heathrow Secondary
<input type="checkbox"/> Northwood School	<input type="checkbox"/> Uxbridge High School

Parent/Carer Details

Parental consent is required in order to submit this self-referral form.

First Name		Phone Number	
Last Name		Email	
Relationship to young person		Main Language Spoken	
Home address (if different from child) City Postcode		Is a translator required?	
		Preferred contact method e.g. email, phone	

Young Person's Details

Please complete all boxes

First Name		NHS Number (If known)	
Last Name		Gender	
GP practice name and address		Main Language Spoken	
Date of Birth		Religion	
School Year Group		Ethnicity/Race	
Young person's phone number (if over 16)		Young person's email (if over 16)	
Home Address City Postcode			
Does the young person have a physical disability or health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any previous experience of CAMHS services/ diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the young person have a learning disability or difficulty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any previous or current involvement from social care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the young person have an Education, Health and Care plan (EHCP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Please give details in relation to any of the above:			

Please note CAMHS is a 9am to 5pm Monday to Friday service (and is closed bank holidays). For out of hours support, please call our Urgent Advice Line (Freephone): 0800 023 4650 which is open 24 hours a day, 7 days a week, 365 days a year or contact your local out of hours GP.

CNWL share your clinical information with other healthcare professionals involved in your care, to support better informed clinical treatment and help reduce clinical risk. A patient information leaflet is available on request from services and further details can be found on the Trust website.

Reason for Referral

Please give a description of current difficulties and what changes you are hoping to see as a result of this referral

- *When did their difficulties start?*
- *How does this affect them? (i.e. practical, physically or emotionally)*

Intervention type	<input type="checkbox"/> Adolescent Anxiety (1:1) <input type="checkbox"/> Anxiety (Group)
	<input type="checkbox"/> Adolescent Low Mood (1:1) <input type="checkbox"/> Low Mood (Group)
	<input type="checkbox"/> Unsure
Preferred Session Format (You are able to choose more than 1 option)	<input type="checkbox"/> Face to face at school <input type="checkbox"/> Online
	<input type="checkbox"/> Face to face at a local family hub or Children's Centre (Coteford Children's Centre, Uxbridge Family Hub, Yeading Children's Centre, Harefield Children's Centre or Hayes Family Hub) <input type="checkbox"/> Whatever is available first

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Agreement	
The information provided in this form may be shared with other agencies if we are concerned for your safety or someone else	<input type="checkbox"/> I agree
Do the parents/carer/guardians (who have parental responsibility) consent to this referral if the young person is under 16 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> Not applicable <input type="checkbox"/> No
Do the parents/carer/guardians (who have parental responsibility) consent to this referral if the young person is over 16 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> Not applicable <input type="checkbox"/> No
If a parent/carer is completing this referral form, has the young person also given consent?	<input type="checkbox"/> Yes <input type="checkbox"/> Not applicable <input type="checkbox"/> No
<p>We may need to provide your personal information to another organisation to comply with our legal obligations, to carry out a public task, or for reasons of public interest.</p> <p>We may also need to share your information if this is within your best interests, for example, if you require urgent care or there are safeguarding concerns.</p>	
In order to provide this service, The Hillingdon Mental Health Support Team (MHST) will need to process data relating to the child / young person, as well as their parent/carer. Do you consent to this?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>In order to provide a collaborative service for you, The Hillingdon MHST may need to share your information with other service providers. We will only share your data with consent. Consent can be withdrawn at any time.</p> <p>Sharing data within the service and other services will be discussed with you before any action is taken. Please tick the boxes, where you consent for data to be shared with:</p>	<input type="checkbox"/> A service that you are already accessing/due to access/recently accessed <input type="checkbox"/> A new service (referral) that would benefit the client (The client requires a different service from what is being offered by Hillingdon MHST) <input type="checkbox"/> Your child's GP <input type="checkbox"/> Your child's school <input type="checkbox"/> Other
I certify that the information I provided is true to my knowledge and that I/my child attend one of the schools listed above	<input type="checkbox"/> Yes
Today's Date (DD/MM/YYYY)	
<p>If you would like to provide feedback regarding the self-referral process please email us at cnwl.adminhillingdonmhstcamhs@nhs.net</p>	

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