REFERRAL FORM

Community mental health for children, young people and young adults, ages 7 to 25

How to refer: submit this form by email to referrals@blip.org.uk, via our online referral form at blip.org.uk/refer, or by online consultation.

We do not require a standardised referral format. A brief clinical summary with the young person's age, presenting concerns, urgency, and your contact details is sufficient.

A care navigator will contact the family within 24 hours of receiving a referral. We will copy you into all correspondence unless the family requests otherwise.

1. Referral Details (Staff to complete)

Referral date	
Referral source	
If other, specify	
Referral method	
Referral received by	
Blip referral reference (office use)	

2. Young Person (Referrer to complete)

First name		**Last name**	
Date of birth		**Age at referral**	
Gender (as described by young person)		**Preferred pronouns**	
Ethnicity		**First language**	

Home address	
Postcode	
School or college (if applicable)	
Year group	
NHS number (if known)	
GP name and practice	
GP address / postcode	

Does the young person have any communication or accessibility needs?

- ☐ No known needs
- ☐ BSL interpreter required
- ☐ Neurodevelopmental communication needs
- ☐ Interpreter required (language below)
- ☐ Easy read / simplified communication
- ☐ Other (detail below)

Language / detail.

3. Parent or Carer (if applicable)

Complete for young people under 18, or where a parent or carer is involved in the referral.

Parent / carer full name	
Relationship to young person	
Telephone	
Email	
Home address (if different from young person)	
Parental responsibility confirmed?	Yes / No / Shared (detail below)
Parental responsibility detail (if shared or complex)	

Does the parent or carer consent to this referral?

- ☐ Yes
- ☐ No (explain below)
- ☐ Young person self-referring at 16+ without parental involvement

Detail if no, or if complex.

4. Presenting Concerns

Select all that apply:

- ☐ Anxiety (generalised)
- ☐ Social anxiety
- ☐ Panic attacks
- ☐ OCD presentations
- ☐ Specific phobias
- ☐ Depression or low mood
- ☐ Emotional dysregulation
- ☐ Self-harm (low to moderate risk)
- ☐ Eating difficulties
- ☐ School refusal or EBSA
- ☐ ADHD-related emotional needs
- ☐ Autism-related emotional needs
- ☐ Trauma or PTSD presentations
- ☐ Family or relational difficulties
- ☐ Bereavement or loss
- ☐ Transition difficulties
- ☐ Sleep difficulties
- ☐ Other (describe below)

Description of presenting concerns
Describe the main concerns in your own words. Include when they started, how they have changed, and the impact on the young person's daily life, education, and family.

5. Risk

If there is immediate risk to the life of the young person or others, do not complete this form. Call 999 or direct the young person to A&E immediately.
For urgent mental health crisis, call 111 (option 2). For Papyrus HOPELINE247: 0800 068 4141. For Samaritans: 116 123.

Current risk of self-harm:

☐ None identified
☐ Low (thoughts without intent or plan)
☐ Moderate (some history or current ideation with protective factors)
☐ High (active intent or plan - contact Blip by phone immediately)

Current risk of suicide:

☐ None identified
☐ Low (passive thoughts only)
☐ Moderate (some ideation, no active plan)
☐ High (active ideation or plan - do not refer by form, call Blip or 999)

Risk to others:

☐ None identified
☐ Some concern (detail below)

Are there any current safeguarding concerns?

☐ No
☐ Yes - referral has been made to MASH or equivalent
☐ Yes - concern present but not yet referred (contact Blip before submitting)

Risk and safeguarding detail
Describe any risk factors, protective factors, previous incidents, current safety plan, or safeguarding referrals. Include dates where relevant.

6. Current and Previous Support

Current involvement (select all that apply):

- ☐ Currently open to NHS CAMHS
- ☐ Discharged from NHS CAMHS
- ☐ Currently open to social care
- ☐ No current support
- ☐ On NHS CAMHS waiting list
- ☐ Currently receiving private therapy or support
- ☐ Currently open to SEND support or EHCP
- ☐ Other (detail below)

Detail of current support
Include provider names, frequency of contact, and reason for parallel or additional referral to Blip.

Previous support (select all that apply):

- ☐ Previous NHS CAMHS involvement
- ☐ Previous private therapy
- ☐ No previous support
- ☐ Previous inpatient admission
- ☐ Previous social care involvement
- ☐ Other (detail below)

Detail of previous support and outcome
Include what was tried, what helped, and what did not.

7. Relevant History

Select any that are relevant:

- ☐ Diagnosis of ADHD
- ☐ Diagnosis of autism / ASD
- ☐ Other neurodevelopmental diagnosis
- ☐ Physical health condition
- ☐ Looked-after child or care leaver
- ☐ Young carer
- ☐ Adverse childhood experiences (ACEs)
- ☐ Bereavement
- ☐ Domestic abuse in the household
- ☐ Parental mental health difficulties
- ☐ SEND or EHCP in place
- ☐ Previous or current involvement with youth justice

Relevant history detail
Include any diagnoses (confirmed or under investigation), medication, known triggers, family context, or other relevant background.

8. Urgency and Preferences

Clinical urgency:

☐ Routine (within our standard 3-week assessment window)

☐ Soon (within 2 weeks - please explain below)

☐ Urgent (within 1 week - please explain below and consider calling Blip)

Reason for urgency (if soon or urgent).

Preferred appointment times:

☐ Morning (9am to 12pm)

☐ Afternoon (12pm to 5pm)

☐ After school or work (5pm to 8pm)

☐ Saturday morning

☐ No preference

Preferred appointment format:

☐ Video (online)

☐ In person (Oswestry, Shrewsbury, Wrexham, or Telford - from month 12)

☐ No preference

Preferred clinician gender (if any)	
Any other preferences or requirements	
Funding source	
Insurer name (if applicable)	
Insurer policy number (if applicable)	
Commissioner name (if applicable)	

9. Referrer Details

Referrer full name	
Job title / role	
Organisation	
Relationship to young person	
Telephone	
Email	
Address	
Copy referrer into correspondence?	

Signature (if sending by post)	
Date	

10. Consent and Data Use

Blip Healthcare Ltd is registered with the Information Commissioner's Office as a Data Controller.
Personal information provided on this form will be used to assess and process this referral and to provide clinical services. It will be stored securely in our clinical record system (WriteUpp), which is UK-hosted and encrypted.
We will share information with other professionals involved in the young person's care only where clinically necessary or where we are legally required to do so.
You can request a copy of the information we hold at any time. Our privacy notice is at blip.org.uk/privacy.

Referrer confirmation (required):

☐	I confirm that, to the best of my knowledge, the information in this form is accurate.
☐	I confirm that I have obtained consent (or Gillick competence applies) for this referral and for the young person's information to be shared with Blip Healthcare Ltd.
☐	I understand that submitting this form does not guarantee acceptance and that Blip will contact me if further information is needed or if the referral is outside our clinical scope.
☐	I understand that Blip will share its referral acknowledgement and correspondence with the referrer unless the family requests otherwise.

11. For Blip Use Only

Referral received by	
Date and time received	
Acknowledgement sent to referrer?	
Acknowledgement sent to family?	
Date acknowledgement sent	
Triage outcome	
Triage completed by	
Date of triage	
Urgency grading	
Allocated clinician	
Assessment date offered	
Assessment date confirmed	
Safeguarding screen completed?	
Safeguarding concern identified?	

Referral entered in WriteUpp?	
Case ID (WriteUpp)	