National and Specialist CAMHS

**National Adoption and Fostering Clinic**

Michael Rutter Centre for Children and Young People

Maudsley Hospital

De Crespigny Park

London SE5 8AZ

Team Mob: **075 9689 2771** (Mon-Fri, 10am – 5pm)

Tel (main clinic reception): **020 3228 3381**

Email: [caftservice@slam.nhs.uk](mailto:name.name@slam.nhs.uk)

Website: <http://www.nationaladoptionandfosteringclinic.com/>

**Referral to the National Adoption & Fostering Clinic**

Thank you for your enquiry regarding a referral to the National Adoption and Fostering Clinic.

**Our service**

Our service is an NHS service for adoptive and foster families. We are situated in London but work with families both nationally and internationally, face to face and remotely.

We offer **comprehensive and holistic assessments** of children and young people who have been fostered or adopted. We are committed to understanding children as individuals, **personalising** our assessments and treatments to each family.

Unlike most specialist NHS services, we are not organised around one type of disorder or Care Pathway, but instead we can explore multiple difficulties and make **complex differential diagnoses** simultaneously.

Our team has high levels of clinical expertise across the most specific problems adopted or fostered children will encounter including **trauma, attachment and life story issue**s. At the same time, we can assess for a **wide range of mental health disorders** such as anxiety, depression, ADHD, autism, behavioural problems, dyslexia, self-harming, risky behaviours etc.

Please refer to our webpage for more details. <http://www.nationaladoptionandfosteringclinic.com/>

**Process of referral**

1. The referrer needs to fill in a **referral enquiry form (see below)**
2. On receiving this and on the basis of the information provided, we will let the referrer know if this is an appropriate case for our service. We may need to contact the referrer for more information, so please fill in the email and phone numbers, and best times to be contacted.
3. If we accept the referral, we **will send a quote** to the professional that is arranging the funding (either from the Adoption Support Fund (ASF) or other sources), who tends to be the referrer (e.g. the Post Adoption Support Worker, a Social Worker or a colleague Mental Health Worker).
4. The person arranging funding will liaise with their department to organise this.

**Process of payment**

Once the funding has been agreed and granted, the Social Worker/person arranging funding needs to **send a Purchase Order number** for the amount to our Referrals Coordinator Toni Cole at ([CAFTService@slam.nhs.uk](mailto:CAFTService@slam.nhs.uk)).

Please note:

* This has to be included in a separate document *with your department’s* *headed paper*.
* Your Business Support Team should not require an invoice prior to generating a PO number – this would not be standard procedure, especially as we already know exactly what the cost of this assessment package will be. We need to receive a PO number prior to generating an invoice. Our finance department will not generate an invoice without a PO number being provided beforehand. If you have any query about this, please contact Toni Cole directly (020 3228 25461).
* Your department will be invoiced after the 1st assessment. There is normally substantial work done before that session, and also a lot of liaison with multiple agencies after assessment, and the final report may take weeks after the face-to-face session. This depends on how quickly we can arrange interviews with school or other informants, when we get the questionnaires back, and the corrections to the draft from the family.

Once we have this, we can offer the family an appointment.

**Form**

Please fill the Referral Enquiry Form on the next page.

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Tel: 020- 3228-2546

[caftservice@slam.nhs.uk](mailto:caftservice@slam.nhs.uk)

**National Adoption and Fostering Clinic**

**Referral Enquiry Form**

|  |  |
| --- | --- |
| **Child/Young person** | |
| **Name:** | **DoB:**  **Age:** |
| **Legal status (who has Parental Responsibility):** | **Ethnicity [see Page 5]**  **Religion:** |
| **Address:** | **Date of referral:** |
| **GP details:** | **School/college:** |
| **Carer (Name, Relationship to child/YP. Contact details, Email, Phone)** | |
|  | |
| **Referrer (Name, Role, Organisation, Contact details, Email, Phone):** | |
|  | |
| **Post Adoption Support Worker (if different from referrer)**  **(Name, Role, Organisation, Contact details, Email, Phone):** | |
|  | |
| **Other agencies/professionals involved**  **(Name, Role, Organisation, Contact details, Email, Phone):** | |
|  | |
|  | |
|  | |
|  | |
|  | |
| **Referral** | |
| **Brief background (**if known)  **Reasons for referral** (If possible, please list the main problems that require assessment).  **Desired outcome of referral** | |

**Ethnicity**

Which of the following categories best describes the patient’s / service user’s ethnicity / ethnic origin?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Asian / Asian British** | | **Black / Black British** | | **Mixed Race / Mixed Race British** | |
| Bangladeshi |  | African |  | White and Asian |  |
| Chinese |  | Caribbean |  | White and Black African |  |
| Indian |  | Other Black background |  | White and Black Caribbean |  |
| Pakistani |  |  |  | Other Mixed Race background |  |
| Other Asian background |  |  |  |  |  |
| **Other ethnic group** | | **White / White British** | | Prefer not to say |  |
| Arab |  | British / English / Northern Irish / Scottish / Welsh |  |
| Other ethnic group |  | Gypsy or Irish Traveller |  |
|  |  | Irish |  |
|  |  | Other White background |  |

We want everyone to have equal access, experience and outcomes from our services. We would like to collect the following information to help us understand if this is happening. The information you give will be kept confidential and will only be used in an anonymised way so no individual is identified.

**NHS Accessible Information Standard**

|  |  |
| --- | --- |
| 1. Does the service user have any communication needs arising from a disability? | Yes or No |

|  |  |  |
| --- | --- | --- |
| 1. If Yes, please specify any communication needs below: | | |
| 1. Do they require communication support? | Yes or No | Please specify required communication support: |
| 1. Do they require a specific contact method? | Yes or No | Please specify required contact method: |
| 1. Do they require information in a specific format? | Yes or No | Please specify required format: |
| 1. Do they require and communication professional? | Yes or No | Please specify type of communication professional: |

**PLEASE RETURN COMPLETED FORM VIA SECURE EMAIL OR PASSWORD PROTECTED**

[caftservice@slam.nhs.uk](mailto:caftservice@slam.nhs.uk)

**THANK YOU**