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| Paediatric Services Referral Form |

**Please refer to Service Information Sheet for Specific Inclusion/Exclusion Criteria.**

**Denotes Mandatory Field**

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| **Please Tick ALL Therapies referred to**  |
| Occupational Therapy |  | Physiotherapy |  |
| Speech & Language Therapy |  | Paediatric Continence Service (Additional Needs only) |  |
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| **Personal Details** |
| Name  |  | DOB.  |  |
| Gender  |  | Ethnicity |   |
| Address *(Inc. Postcode)* |  | NHS No |  |
| **Person with Parental Responsibility (PR)** |
| Name  |  | Relationship to Child  |  |
| Address if differs to the Child  |  |
| Home Contact Number (if differs)Indict preferred no. |  | Mobile Contact Number (if differs)Indicate preferred no. |  |
| Email address |  |
| Details of who child lives with **if different to person with Parental Responsibility (or N/A)** |
| Does this patient or the patient’s family pose a risk to a lone worker **Yes** **No**  |
| **Safeguarding information:****Is the patient a Looked After Child : Yes No** **Is the child on a protection plan or on child in need plan: Yes No** **Are there any safety issues/risks for the child or others (arising from child’s needs)? Please specify**: |
| **Primary Reason for Referral** |
| **Medical Diagnosis/Medication/Investigations/hearing test results or known hearing history or vision.**  **Difficulties affecting child’s day to day function** |
| **What interventions have been tried or are currently in place (home and/or school/nursery)****What was the outcome?** |
| **Referral Source** |
| Referrer’s name |  | Job Title |  |
| Contact Number |  | Secure email address |  |
| Referrer’s Contact Address/Base |  | GP/Ward name |  |
| **School/Nursery** |
| Name of School, Nursery or Home Schooled  |
| SALF Attached **SALF form must be attached for one plan/ EHCP if SALT referral**  **Yes No**  | School Year Group |  |
| On a One Plan **Yes No**  |  |  |
| Education Health **Yes No** Care Plan  |  |  |
| **Other Professionals involved:** | **Yes** | **Name** |
| Paediatrician |  |  |
| Social Worker |  |  |
| Other |  |  |
| **Observations from person with parental responsibility** |
| **How does the child or young person’s difficulty affect him/her at home or at nursery/school?** |
| **What is the impact of his/her difficulties on the child/family (is child easily understood? and what are the child’s views) Is he/she aware?** |
| **Communication Needs** |
| Language spoken at home? | If an interpreter needed - which language?  **(or N/A)**  |
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| **For Speech and Language Therapy referrals please indicate main area of concern**  |
| Feeding & Swallowing |  | Not speaking/slow to speak |  |
| Understanding |  | Speech Sounds |  |
| Making Sentences |  | Voice (hoarse/weak) |  |
| Stammer/Stutter |  | Hearing Impairment |  |
| Relating to others |  | Learning Disabilities |  |

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| **For Paediatric Continence (for children with additional needs and over 3 years) please indicate main area of concern**  |
| Toilet Training  |  | Soiling |  |
| Bed wetting (nocturnal enureisis) |  | Other |  |
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| For Occupational Therapy referrals  |
| **What are the child’s functional difficulties? Please tick the relevant box. If more than one difficulty identified, please state which is the primary area for initial input:** |
| Fine Motor |  | Equipment needs (including seating) |  |
| Daily Living Skills |  | Moving and Handling |  |
| Housing (minor/major adaptions, safety issues) |  | Co-ordination difficulties, please state if referring to Physiotherapy |  |
| Physical Disability |  | Related to a planned surgery (please include date if known) |  |
| Sensory |  |  |  |
| **Please attach any relevant reports** |
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| **For Physiotherapy referrals**  |
| **Please note we do not accept referrals for children with the following:** |
| Toe-walking children with ASD who can stand with their heels on the floor | Reason: Physiotherapy input has been shown to have no lasting effect |
| Child under 20 months of age who is not yet walking | Reason: this is age appropriate |
| Symmetrical feet rolling in/outwards up to 4 years of age | Reason: This is age appropriate.Please do refer children under 5 years with asymmetrical foot positions/children 5 years and over |
| Curly toes/toes curling under | Reason: Physiotherapy input will have no impact on this. |
| Flat feet | Reason: This is within the normal developmental range for children under 5 yearsIf the child’s foot position is impacting on function please refer to the Podiatry Service |
| **Pain: If the child is experiencing constant pain please also refer to the Community Paediatric Service** |
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| **Consent**  |
| **The person with parental responsibility has consented to this referral.**  | **Yes/No**  |
| **The person with parental responsibility has consented for phone messages to be left on the numbers they have provided.**  | **Yes/No** |
| **The person with parental responsibility has consented for email contact to be made.**  | **Yes/No** |
| **The person with parental responsibility has given consent for the child to be seen in nursery/school.** | **Yes/No**  |
| **Text messages****Information sharing with relevant professionals/agencies** | **Yes/No** |

**Forms with missing mandatory information will be returned and could lead to a delay in acceptance of referral and service commencement.**

**Please refer to the Community Services website www.neecommunity.org.uk and click on Our Services for more information on service acceptance and exclusion criteria.**