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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) | | | |  |
|  | | | | |  |  | | | |  |
| **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)** | | | | | | |
|  | | | | | | | | | | |
| **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 | |  |
|  | | | | |
| 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** | | | | |
|  | | | | | |
| **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 years  If 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** | | | | |
|  | | | | |
| **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.**