

Providing care on behalf of North East Essex Community Services Collaborative



<Patient Name> <Date of birth> <NHS number> Page **1** of **5**

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| Paediatric Services Complex Communication Referral form for a new Episode of Care |

Please email completed referral forms to: communitygateway@esneft.nhs.uk

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| **Personal Details** |
| Name  | <Patient Name> | DOB.  | <Date of Birth> |
| Gender  | <Gender> | Ethnicity | <Ethnicity> |
| Address *(Inc. Postcode)* | <Patient Address> | NHS No | <NHS number> |
| **Person with Parental Responsibility (PR)** |
| Name  | <Relationships> | Relationship to Child  | <Relationships> |
| Address if differs to the Child  | <Relationships> |
| Home Contact Number (if differs)Indict preferred no. | <Relationships> | 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**:      |
| **Date last Episode of Care ended (date of last SLT visit/last report):**  |
| **What can you tell us about the last Episode of Care? Are the recommendations still in place? If not, can you please explain the circumstances around this?****Please use this space to tell us about any changes that have taken place that may be impacting on the previous SALT recommendations being followed.**     **Why do you need a new Episode of Care? What do you now need help with?****We may need to contact you to discuss this referral, please provide a name and contact number of someone who knows the child and circumstances well, e.g., their key person in the nursery.** |
| **Referral Source** |
| Referrer’s name | <Sender Name> | Job Title |       |
| Contact Number | <Sender Details> | Secure email address | <Organisation Details> |
| Referrer’s Contact Address/Base | <Sender Address> | GP/Ward name |       |
| **School/Nursery** |
| Name of School, Nursery or Home Schooled <Patient School> |
| **Other Professionals involved:** | **Yes** | **Name** |
| Paediatrician |  |       |
| Social Worker |  |       |
| Other |  |       |
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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** |