Logo

Description automatically generated

Providing care on behalf of North East Essex Community Services Collaborative

Logo

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<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](mailto: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** |