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| **Please return completed forms to:**  [**LHNT.community-paediatrics@nhs.net**](mailto:LHNT.community-paediatrics@nhs.net)  **Paper copies will not be accepted.** |



**Community Paediatrics Referral Form**

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| **Please fill in as much of this form as you can. The more information you give us, the better we can screen the referral and establish an appropriate route forward for this young person.**  **Please note: if this referral is from a school, you do not need to duplicate areas of information already covered on this referral form on the ‘School Questionnaire’.**  **The following information must be included with this referral form before the team will look at the referral:**  **Consent Form**  **Parent Questionnaire**  **School Questionnaire OR  Not applicable; child is not in education setting** (*Childcare, Nursery, Pre-school, School, College)*    **Inclusion of additional reports is encouraged but please be advised that any additional information will only be considered once the initial information has been screened and the young person has been accepted into the service.**  **Please confirm that the person with Parental Responsibility has given consent for this referral to be made.**  **Consent *has* been given  *(Referrals will not be accepted if consent has not been given)***  **Thank you for your time.** |

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| **Suspected area of need.** | *Please select* ***one*** *box that most accurately describes the suspected area of need.* |

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| Concerns around social communication, interaction with others and/or unusual behaviours  **This is an assessment pathway, however we may signpost you to other services for advice, support or intervention where this is indicated.**  There are many conditions that can include difficulties with social communication/interaction for children and young people. This includes conditions such as hearing loss, speech and language difficulties, learning difficulties, dyspraxia, depression and anxiety, bullying and emotional worries about the home. It’s important, therefore, to consider such possible contributing factors before making a referral to the service and during the assessment process. Before referring a child for an assessment for social communication and interaction concerns, please make sure the checks outlined below have been taken.  **Before filling out this referral, please ensure the following inclusion criteria are met and detailed in the referral form:**  **For children under age 4:**   * The child has had a developmental check within the past 12 months * Check that the child and family have been offered first line intervention and support. This could include parenting support and advice through Health Visitor, pre-school/nursery, school or a family support worker through Early Help. * There has been a hearing test to rule out hearing difficulties where this is an identified area of concern. * Referral to Speech and Language Therapy has been made where there are identified concerns about the child’s speech or language skills. * Check that there are reported symptoms of a pattern of impairments in reciprocal social and communication skills, together with unusual restricted and repetitive behaviours that may indicate possible autism in the referral. (refer to NICE guideline Autism spectrum disorder in under 19s: recognition, referral and diagnosis (CG128)   **For children aged 5-16**   * Make sure that needs-led support is in place within the school environment. Children and young people should be able to access appropriate support in school regardless of whether a diagnosis is made. * Check that the child and family have been offered first line intervention and support. This could include parenting support and advice through school, or a family support worker through Early Help. * For older children, check that difficulties with social interaction, communication and restrictive behaviours pre-date secondary school and have been present since early childhood * Check that there are reported symptoms of a pattern of impairments in reciprocal social and communication skills, together with unusual restricted and repetitive behaviours that may indicate possible autism in the referral. (refer to NICE guideline Autism spectrum disorder in under 19s: recognition, referral and diagnosis (CG128)   Attention Deficit Hyperactivity Disorder (ADHD)    **For children aged 6-16**   * Children under 6 years of age are not appropriate for this pathway. * Make sure that needs-led support is in place within the school environment. Children and young people should be able to access appropriate support in school regardless of whether a diagnosis is made. * Check that the child and family have been offered first line intervention and support. This could include parenting support and advice through school, or a family support worker through Early Help. * Check that the child has difficulties with inattention, and/or hyperactivity and impulsivity (referred to as symptoms below) * These symptoms are found in more than one setting (home and school) * These symptoms were present before the age of 12 * These symptoms have been present for six or more months * These symptoms are impairing the child’s functioning and development * These symptoms are not better explained by another conditions such as adverse life events, environment, substance misuse, depression or anxiety   Neurodevelopmental Concerns (developmental regression, moderate to severe developmental delay,  cerebral palsy, genetic conditions) |

**Referrer Details**

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| **Name of Referrer making request** | |  | | | |
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| **Referrer’s job title and location** | |  | | | |
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| **Referrer’s Address** |  | | | | |
|  | | | | | |
| **Referrer’s e-mail address** |  | | | **Referrer’s contact telephone number** |  |
|  | | | | | |
| **Date Form Completed** | | |  | | |

**Child Details**

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| **Child’s Name** | | |  | | | | | **NHS number** | | | **F** | | | |
|  | | | | | | | | | | | | | | |
| **Date of Birth** | | |  | | **Age** |  | | | | | **M** |  | **F** |  |
|  | | | | | | | | | | | | | | |
| **Address** |  | | | | | | | | | | | | | |
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| **Postcode** |  | | | | **Telephone Number** | | | | |  | | | | |
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| **GP Practice** | |  | | | **School** | |  | | | | | | | |
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| **Language spoken** | **Interpreter required?** | | | | **Interpreter**  **required** | | | | Yes  ☐  No  ☐ | | | | | |
|  | | | | | | | | | | | | | | |
| **Looked after child** | | | | Yes  ☐  No  ☐ | | | | | | | | | | |

**Parent/Carer Details**

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| **Name** | | |  | | | | | | **M** |  | **F** |  |
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| **Relationship to child** | | | **Age** | | | | | | | | | |
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| **Address (if different)** |  | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Telephone Number** | | | | |  | **Email address** | |  | | | | |
|  | | | | | | | | | | | | |
| **Parental Responsibility** | | Yes    No | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Parent Language spoken** |  | | | | | | **Interpreter**  **required** | Yes    No | | | | |
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| **Written English understandable** | | | | Yes   No | | | | | | | | |
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| **Reason for Referral *(Please provide a brief description of your reasons for supporting a referral to the Community Paediatric Team)*** |
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| **Professionals involved with the child (please state details if known)** | | | |
| **Service/**  **Professional** | **Current or past and estimated dates** | **Reason for involvement** | **What support was received** |
| Speech and Language Therapy: | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Paediatrician: | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Occupational Therapy: | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Child and Adolescent Mental Health Service (CAMHS): | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Healthy Minds: | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Physiotherapy: | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Educational Psychology: | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Children and Young People’s Nurse: | Current/Past  Start date  ………………  End date:  ……………… |  |  |
| Social Worker: | Current/Past    Start date  ………………  End date:  ……………… | Open to Child in need: Yes/No  Reason:    Open to Child Protection: Yes/No  Reason: |  |
| Early Years inclusion team (for example Portage, SENCO): | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Early Help Worker | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Working Together Team | Current/Past    Start date  ………………  End date:  ……………… |  |  |
| Behaviour Outreach Support Service (BOSS) | Current/Past    Start date  ………………  End date: |  |  |
| **Other – please list below:** |  |  |  |
|  | Current/Past  Start date  ………………  End date:  ……………… |  |  |
|  | Current/Past  Start date  ………………  End date:  ……………… |  |  |

**Thank you very much for providing this information**