**Please complete this form for:**

* **Children of all ages for Dietetics**
* **Children over 5 for Physiotherapy, Occupational Therapy, and Speech and Language Therapy**
* **Children under 5 year with the following identified needs:**

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| **Speech and Language Therapy**  Identified through social care pathway  Acute Discharge from Hospital  Eating and drinking (dysphagia needs) | **Occupational Therapy**  Identified through social care pathway  Acute discharge from Hospital | **Physiotherapy**  Identified through social care pathway  Acute discharge from Hospital  Talipes  Torticollis  Erbs Palsy  Gait clinic  Acute exacerbation of a previous respiratory condition  Management of a respiratory condition eg Asthma |

**Please direct all other under 5 children requiring Physiotherapy, Occupational Therapy or Speech and Language Therapy to our drop-in assessment and advice sessions.**

Please complete all fields in full including the relevant appendice(s) for the referral team. Incomplete forms will be automatically rejected and returned.

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| **Please indicate the profession(s) you are referring the child/young person to and complete the relevant appendice as indicated** | | | |
| Speech and Language Therapy | ❑ (Appendix 1) | Physiotherapy | ❑ (Appendix 2) |
| Occupational Therapy | ❑ (Appendix 2) | Dietetics | ❑ (Appendix 4) |

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| **Child’s Details (BLOCK CAPITALS)** | | | | | | | |
| Surname: | | | First name: | | | | DOB: |
| Gender: | | | Ethnicity: | | | | NHS no (if known): |
| Parent/carer names: | | | 🕿 Home: | | | | 🕿 Mobile: |
| Who has parental responsibility for the child? | | ❑ | As above | | | | |
| ❑ | Other - please provide details: | | | | |
| Home language: | | | | Interpreter required: Yes / No | | | |
| Home address:  Postcode: | **All correspondence will be sent to this address unless otherwise indicated.** | | | | | | |
|  | | | | | | | |
| GP name and address: |  | | | | | | | |
| Health visitor / School nurse: |  | | | | | | | |
| School/pre-school: |  | | | | | | | |
| Class teacher/  SENCo/LSA: |  | | | | Class/year group: |  | | |

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| **Please indicate which of these services are, or have been, involved with this child:** | | | | | |
| ❑ | Hospital Consultant | ❑ | Occupational Therapy | ❑ | Educational Psychology |
| ❑ | Community Paediatrician | ❑ | Physiotherapy | ❑ | Social Services |
| ❑ | Dietetics | ❑ | Speech & Language | ❑ | Health Visitor / School Nurse |
| ❑ | CAMHS | ❑ | Music Therapy |  |  |
| ❑ | Other (please specify): | | | | |

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| **Please complete for each agency currently working with the child/young person/family** | | | |
| Name of service provider | Contact Details | Length / date of treatment | Additional information / Report enclosed? |
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| **Relevant History** |
| Please attach any relevant reports (e.g. medical, educational) and provide relevant information relating to medical / family / social history. |

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| **Referrer details** | | | | | |
|  | Signature of referrer: |  | Date: |  |  |
|  | Print name: |  | Role: |  |  |
|  | Contact address: |  | | |  |
|  | Contact no: |  | | |  |
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| **Referrals for children aged 15 years and younger**  **Parent/carer consent** (Requests cannot be accepted without the consent of the parent/guardian.) | | | | | | |
| *I give my consent for this request and any therapy assessments that may be required, in addition to information being shared with the appropriate statutory agencies as long as it is in the best interest of my child. I confirm that I understand that the information in the referral form and actions taken will added to my child’s electronic healthcare records.* | | | | | | |
|  | Signature of parent/carer: | |  | Date: |  |  |
|  | Print name: | | | | |  |
| **Referrals for children aged 15 years and younger**  **For Health Visitors only:** | | | | | | |
| *I confirm that I have discussed this referral with the child’s parent/guardian and have their consent to make the referral for an assessment. They give their consent to this request and any assessments that may be required. I confirm that I have discussed the information contained in the referral form and I have noted parental/carer consent on electronic healthcare records.* | | | | | | |
|  | Signature of Health Visitor: | |  | Date: |  |  |
|  | Print name: | |  |  |  |  |
| **Referrals for young people aged 16 years and older:**  A young person’s capacity to consent to this referral, will need to be confirmed when s/he attends their first appointment | | | | | | |
| If young person is aged 16 and older, have they given their agreement for this referral? | | | | | | |
| ❑ | | YES | | | | |
| ❑ | | NO – please explain why they have not OR are unable to agree referral: | | | | |
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**Appendix 1 – Speech and Language Therapy**

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| Please indicate the level of concern for this child/young person from both the school and parent(s) perspectives, for each of the areas listed below. | | | | | | | | |
|  | **No concern** | | **Mild concern** | | **Moderate concern** | | **Significant concern** | |
| School | Parent | School | Parent | School | Parent | School | Parent |
| Play / social skills |  |  |  |  |  |  |  |  |
| Attention & listening |  |  |  |  |  |  |  |  |
| Understanding |  |  |  |  |  |  |  |  |
| Expressive language |  |  |  |  |  |  |  |  |
| Speech sounds (clarity) |  |  |  |  |  |  |  |  |
| Chewing / swallowing |  |  |  |  |  |  |  |  |
| Stammering |  |  |  |  |  |  |  |  |
| Selective mutism / reluctance to talk |  |  |  |  |  |  |  |  |

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| Has this child/young person received support from the speech and language therapy service previously? | | YES ❑ | NO ❑ |
| If YES, when? |  | | |

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| **Reasons for requesting assessment** Please put as much information here as possible |
| What has prompted you to make this request for assessment today? |
|  |
| What strategies have you tried already? What is in place now to support the child/young person? |
|  |
| How successful have these strategies been? |
|  |
| What do you hope this request will achieve? |
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| What impact do the above concerns have on this child/young person, as you see it? |
|  |
| What impact do the above concerns have on the child/young person as the class/nursery teacher sees it? |
|  |
| What is the impact of the above concerns, from the perspective of the parent(s) / carers? |
|  |
| What is the impact of the above concerns from the perspective of the child/young person?  (i.e. their awareness of the concern, the impact it has on their life) |
|  |
| Any other information: |
|  |

**Appendix 2 – Physiotherapy** ❑ **and/ or Occupational Therapy** ❑

If you are unsure which team to refer to please contact the Children’s Therapies Team on 020 8836 8621 option 2

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| Please indicate the main functional concern that impacts on the child’s daily life |
|  |

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| Has this child received support from the Physiotherapy/Occupational Therapy team previously? | | YES ❑ | NO ❑ |
| If YES, when? |  | | |

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| What impact do the above concerns have on this child/young person, as you see it? |
|  |
| What impact do the above concerns have on the child as the class/nursery teacher sees it? |
|  |
| What is the impact of the above concerns, from the perspective of the parent(s) / carers? |
|  |
| What is the impact of the above concerns from the perspective of the child / young person?  (i.e. awareness? Impact on life?) |
|  |
| Any other information: |
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**Appendix 3 – Dietetics**

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| **Dietetics** | | |  |
| Weight (in kg): | Centile: | Date taken: | Other measurements: |
| Length/height (in cm): | Centile | Date taken: |
| Medications | | |
| Relevant feeding history, weight history and reason for referral: | | | |

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| Has this child received support from the Dietetics service previously or under an acute dietetic team? | | YES ❑ | NO ❑ |
| If YES, when? |  | | |