Referral Form for Children’s Health Services

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| **Baby, Child or Young Person’s Details** | | | | | | | **NHS No:** | | | |  | | | | | | **DOB:** | |
| **Surname:** | | | | | **Forename(s):** | | | | | | | | | Also known as: | | | | |
| **Sex: M/ F** | **Ethnicity:** | | | | | **Interpreter required: Y/N** | | | | | | **Language:** | | | | | | **Religion:** |
| **Address:**  **Post Code:** | | | | | | | | | | **Correspondence Address (if different):** | | | | | | | | |
| **Name of GP / address :** | | | | | | | | |
| **Contact Tel No:** | | | | | | | | | | **School or Nursery attended:** | | | | | | | | |
| **Main Carer with Parental Responsibility** | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | Other Carer Name: | | | | | | | | | |
| Relationship: Mother | | Sex: M / F | | DOB: | | | | | Relationship: | | | | Sex: M / F | | | DOB: | | |
| Ethnicity: | | Religion: | | | | | | | Ethnicity: | | | | | | Religion: | | | |
| Address if different from above): | | | | | | | | | Address if different from above): | | | | | | | | | |
| Contact No: | | | | | | | | | Contact No: | | | | | | | | | |
| **Medical Diagnosis/Difficulties** | | | | | | | | | **Current Medication** | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | |
| **Referral Details** | | | | | | | | | | | | | | | | | | |
| **Referral date:** | | | **Referring Agency and Contact Address:** | | | | | | | | | | | | | | | |
| **Referred by:**  Print name: Signature: Contact number: | | | | | | | | | | | | | | | | | | |
| **Referral Priority:** | | | | | | | | **Referral has been discussed with:**    Date: \_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parents/Carers wish to receive copies of letters, reports, referrals | | | | | | | | | | |
| **Reason for Referral:**        Continue on separate sheet if required | | | | | | | |
| **Is Child:**  **□** Early Help **□** Child in Need **□** Child Protection Plan  **□** Looked After Child **□** Adopted **□** Travelling Family  **□** Asylum Seekers **□** No recourse to public funds | | | | | | | | | | |
| **Referred to Service/Speciality\*:** | | | | | | | | **Name of Social Worker:** | | | | | | | | | | |
| **Referred to Team/Clinician:** | | | | | | | | **Social Worker Contact Details:** | | | | | | | | | | |

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| **Birth History :** | | | **Hearing**      **Vision** | |
| **Any Significant Family History:** | | |
| **If referring to Team Around the Child, Speech & Language Therapy, Physiotherapy or Occupational Therapy please describe concerns in any of the following areas :** | | | | |
| **Gross Motor (Physical abilities)** | | | **Fine motor (Co-ordination / hand function)** | |
| **Self-help (Feeding, Dressing & Toileting)** | | | **Play Skills / Social Interaction** | |
| **Attention & Concentration** | | | **Behaviour** | |
| **Communication Skills (tick all that apply)** | | | | |
| **Referral to Speech and Language Therapy (Dysphagia) for problems with oral control for feeding/swallowing – medical referral only:**  *Please give details:* | | | | |
| **Have any Special Educational Needs been identified?** | | **Educational Attainment:** | | |
| **Other Services involved with the child:**  □Physiotherapy □Occupational Therapy □Speech & Language Therapy □Advisory Support Team EYSEN  □Sure Start □ CAMHS □ Clinical Psychology □Vision Impaired  □ Children’s Services (Social Care) □ Other □Hearing Impaired  □Consultant (s) Name …………………………………………………………………………… □ Specific Learning Difficulties (SpLD) | | | | |
| **Any Additional Supporting Information:** | | | | |
|  | | | | |
| **For Occupational Therapy, Physiotherapy or TAC please send referral to relevant department at:**  Child Development Centre  Coalheath Lane  Shelfield  Walsall WS4 1PL  **CDC: Tel: 01922 605800 Fax: 01922 605601**  **PHYSIO:**  **Tel: 01922 605810 Fax: 01922 605601**  **OT: Tel: 01922 605820 Fax: 01922 605601** | **For Speech & Language Therapy please send referral to:**  Blakenall Village Centre  Thames Road  Walsall WS3 1LZ  **Tel: 01922 605400** | | | **For referrals to CAMHS:**  Canalside House  Abbotts Street  Bloxwich  Walsall WS3 3AZ  In cases of emergencies or if you have any queries regarding a referral to the service please contact the Department on:  **01922 607400** |