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:** |
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| **For Occupational Therapy, Physiotherapy or TAC please send referral to relevant department at:**Child Development CentreCoalheath LaneShelfield 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 CentreThames RoadWalsall WS3 1LZ**Tel: 01922 605400** | **For referrals to CAMHS:**Canalside HouseAbbotts StreetBloxwichWalsall WS3 3AZIn cases of emergencies or if you have any queries regarding a referral to the service please contact the Department on:**01922 607400** |