NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

REFERRAL FORM FOR COMMUNITY PAEDIATRIC

Referrals will be accepted from: GPs, Consultants, Hospital clinicians, CAMHS professionals, Educational Psychologists, Specialist nursing professionals, Health Visitors, School Nurses and Allied Health Professionals
Weight Management referrals will also be accepted from Public Health weight management services:

Name:	
NHS number:	
D.O.B:	**Sex M/F**
Ethnic Category:	
Address: **Post Code:**	
Tel No: **Alternative No:**	
Name of Parent/ Guardian with legal parental responsibility:	
G.P (name and address):	
Language spoken at home:	
Interpreter needed:	**Yes/No**
Early Years Setting/School:	

PLEASE COMPLETE ALL SECTIONS IN FULL OR THE REFERRAL MAY BE RETURNED

List other Professionals involved (provide name if known); Name and Base

- ☐ Audiology/ENT _____
- ☐ Other Consultant _____
- ☐ Speech and Language Therapist _____
- ☐ Occupational Therapist _____
- ☐ Physiotherapist _____
- ☐ Educational Psychologist _____
- ☐ CAMHS _____
- ☐ Health Visitor/School Nurse _____
- ☐ LA Vision / Hearing Team _____
- ☐ Social Worker _____
- ☐ Weight management _____
- ☐ Physiotherapist _____
- ☐ FNP _____
- ☐ Continence Service _____
- ☐ Other _____

CAF Completed: **Yes/No**

Looked After Child: **Yes/No**

Known to Social Services: **Yes/No**
Social Worker: _____
Phone number:

Does the parent have any disabilities or support needs: **Yes/No**
Comments: _____

Previously known to Community Paediatricians: **Yes/No**
Date:

	Please tick which areas the child is experiencing difficulties with:	Please explain how these difficulties are affecting the child at home, school, in public venues:
	This child has a diagnosed medical condition / syndrome that requires further assessment	
	This child has significant difficulty with attention, impulsivity and hyperactivity which impact on learning/ behaviour and requires further assessment	

	There are significant concerns about the level of physical or social development or loss of skills already acquired	
	There are significant constipation / enuresis issues requiring doctor involvement: referrals accepted only from continence service	
	OTHER:	

Please list and current medication:

Any Allergies: Yes/No

What strategies or techniques have you tried to overcome these difficulties and how long were they in place before this referral was made? (please attach any other relevant assessment information or recorded observations when you send in this referral)

What was the result of the strategies / techniques put in place?

Please tell us what you hope to gain from referral to our Community Paediatric team?

Parents:

School/ Early years setting:

Child/Young person (if appropriate):

REFERRER DETAILS AND CONSENT:

I confirm that this child has not been referred to another service / agency for the same condition ☐

Referrer's Name: ..... Role: .....

Referrer's Contact Address .....

.....

.....

Referrer's Contact telephone number: ....

Referrer's Signature: ..... Date: .....

Parents informed of referral to Community Paediatric service (essential)

- ☐ Verbal consent if a health professional
- ☐ Written parental consent form completed and attached if not health professional

Is there any other information you have available eg results from 2 year evaluation, EYF stage or education / behaviour information

Parent / Carer Consent Form for Referral **Date:**

(*Please note written consent must be obtained from the parent/carer with parental responsibility for the child)*

- I give consent for my child to be referred to the Community Paediatric.
- I give consent for Bridgewater Health Staff to liaise and consult with other people involved with my child
- I give consent for the Bridgewater Health Staff to share information with other services involved with my child
- I confirm that I have not been referred elsewhere for this same problem

Parent / Carer Name (Print)…….

Signature……..

PLEASE RETURN TO:

St. Helens' Community Paediatricians,
Alexandra Business Park,
2nd Floor Court Building,
Prescot Road,
St. Helens
WA10 3TP

Ref: Form Sept 2015

Phone number: 01744 45 7215