NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

REFERRAL FORM FOR COMMUNITY PAEDIATRICS FOR SPECIAL SCHOOL CHILD
NOT ALREADY ON REVIEW LIST

Referrals will be accepted from: GPs, Consultants, Hospital clinicians, CAMHS professionals, Educational Psychologists, Specialist nursing professionals, Health Visitors, School Nurses, Allied Health Professionals / SENCO

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:	

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 _____
- ☐ Continence Service _____
- ☐ Physiotherapist _____
- ☐ 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 Paediatrician And Name of Paediatrician (if known)	**Yes / No Review date _/_/_** **Dr**
Previous diagnoses	
Medication **Yes / No** **Allergies** **Yes / No**	**Detail;**

PLEASE COMPLETE ALL SECTIONS IN FULL IN ORDER FOR THE REFERRAL TO BE CONSIDERED

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:**
Concerns regarding a neurodevelopmental disorder requiring assessment; i. Autism spectrum disorder Yes / No ii. Attention deficit hyperactivity disorder Yes / No iii. Developmental coordination disorder Yes / No	
Children with diagnosed neurodevelopmental condition(s) / other medical reason causing sleep difficulties. **Children previously diagnosed with neuro developmental conditional and may require medications**	
Significant behaviour problem which may be health related	
Young people with ADHD at 17 & 1/2 years (on medication) to discharge to GP and refer onto adult services if leaving school	
Children with recognized Genetic Syndromes or Neurodevelopmental medical conditions (e.g. Cerebral Palsy) requiring review who are not currently on the caseload	
OTHER:	

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):

Are behaviour strategies / techniques in place to over come any behaviour difficulties in school. (please attach any other relevant assessment information or recorded observations when you send in this referral)

Are Bridgewater Specialist Nurses involved? Yes / No

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 Educational Psychology report, EHCP

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 Service
- 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:

Community Paediatrics and Looked After Children Service
Alexandra Business Park
2nd Floor Court Building
Prescot Road
St. Helens
Merseyside
WA10 3TP