Bridgewater Community Healthcare NHS
NHS Foundation Trust

WARRINGTON Borough Council

CHILDREN (pre school) 4 YEARS AND UNDER COMPLEX CASE REFERRAL FORM
FOR COMPLETION BY PROFESSIONAL ONLY

The complex case panel is a group of health and education professionals working together when a child / young person needs to see more than one professional. If a child only needs a single health agency then use that agency referral form

Referral criteria: We assess and support children with a wide range of needs such as:

- Delay in development
- Physical, vision and hearing impairment
- Social interaction and communication issues
- Swallowing difficulties of a mechanical nature

Child's name _____Male / Female_____ d.o.b._____

Address _____

Postcode _____ Tel: _____ Mob_____ GP Name_____

NHS Number _____ Parent / Carer Full name _____

Does Parent / Carer have any disabilities that we need to consider for the appointments? Yes/No

Ethnicity _____ Is this child on a care pathway? Yes/No/Unknown

Nursery / pre school setting _____

Main language spoken in the home _____ Interpreter needed Yes / No

Please list the names and details of all children and adults who are currently residing with this child:

Surname	First Name	DOB	Relationship to child

Please list all other professionals already involved with this child.

Professional	Name	Phone number	Base

PARENTAL / CARER CONSENT FOR REFERRAL TO COMPLEX CASE PANEL

Signed consent required:

- I had the reasons for the referral explained and I am happy for my child to be considered for assessment
- I understand that information gathering and sharing is beneficial for my child and that information recorded about my child and family may be shared with other agencies (including education) and used for the purpose of providing services for my child.
- I understand that this referral will be discussed at a meeting of Professionals in order for them to work together to provide my child with the support that is best suited to my child's needs.
- I am aware that I may limit the information shared and that I may withdraw my consent at any time. I do not want the information to be shared with ……..
- I understand that I am expected to attend appointments and to carry out recommendations at home as advised by the clinicians.
- I am aware that if another adult brings my child to sessions they will receive all information about my child unless I inform the services otherwise.
- I confirm that I understand if this referral is accepted I will be offered choice of appointment times with the relevant professional in the appropriate setting.
- I understand that if my child's needs are not best met via the complex case panel this form will be returned to the referrer for them to provide future support.

Signature: _____ **Date:** _____

Print name: _____ **Relationship to child:** _____

Practitioner signature: **Date:**

Referrers Printed Name: _____ Base: _____

Agency: _____ Contact No: _____

Email: _____

What do parents / carers wish to happen as a result of this referral?
Does this child have an EHC (education health care plan)? Please circle one **Yes** **No** **Unknown**
Does this child have a CAF / Family Support Plan? Circle **Yes** **No** **Unknown** **If Yes please attach**

Please complete ALL questions for EVERY section

(this allows us to involve the appropriate professional at the outset)

If the child is too young for the question-please leave/score out

DEVELOPMENT, COMMUNICATION AND PLAY

Indicators of concern	Tick yes	/ no
1) Child appears to be losing skills at any age	☐	☐
2) Child has a diagnosed syndrome	☐	☐
3) Child has abnormal eye movement, fixating on objects or not tracking moving objects	☐	☐
4) Child is very quiet at 9 months, has no babble or makes a very limited range of sounds	☐	☐
5) Child has very limited interaction by 18 months eg child does not point or make requests by pointing or showing. Child may often seem "in a world of their own"	☐	☐
6) Child is not able to point to at least 1 body part (eg nose, hair by 18 months)	☐	☐
7) Child is not able to select at least 3 familiar objects from a small choice by 21 months	☐	☐
8) Child communicates mainly on his / her own terms at 24 months and beyond ie mostly to ask for items. It is very difficult to draw child's attention to things.	☐	☐
9) Child mouths or bangs toys together rather than using toys to pretend by 24 months (e.g. putting a hairbrush in their mouth rather than brushing their own hair)	☐	☐
10) Child is not able to play with toys in a pretend way by 30 months ie cannot pretend to brush mum's hair or feed a toy	☐	☐
11) Child has unusual or obsessive interests in particular types of play by 30 months and beyond (e.g. lining toys up, excessive spinning of toys, special interest in washing machines or other electrical equipment)	☐	☐

DEVELOPMENT, COMMUNICATION AND PLAY (continued)

Indicators of concern	Tick yes	/ no
12) Child cannot follow instructions such as **Where's Mummy's hair?, Where's child's shoes?** by 30 months (with no adult gestures or pointing to cue understanding)	☐	☐
13) Child has poor social interaction	☐	☐
14) Child cannot have a conversation by 42 months or repeats what you say rather than responding	☐	☐
15) Child appears to have inappropriate reactions / behaviour to sensory input	☐	☐

Any significant family history relevant to the referral or other information / concerns or observations to support your referral please add below

If there are concerns about other aspects of communication not listed above please refer to the single agency Speech and Language Therapy referral form.

MOBILITY AND MOVEMENT – Gross motor skills

Indicators of concern	Tick yes	/ no
16) Child from birth demonstrates asymmetry in movement eg arm / leg / head	☐	☐
17) Child from 6 weeks appears excessively stiff or excessively floppy eg head / body	☐	☐
18) Child is not sitting independently by 9 months	☐	☐
19) Child is not moving around on the floor by 12 months	☐	☐
20) Child is not walking independently by 24 months	☐	☐
21) Child shows reduced co-ordination / delay in jumping, running, balance skills by 4 years of age	☐	☐

Any other information / concerns or observations to support your referral please add below

If there are concerns about bow legs, knock knees, flat feet or other aspects of mobility please refer to single agency Physiotherapy referral form

FUNCTIONAL SKILLS – Fine motor skills

Indicators of concern	Tick yes	/ no
22) Child is unable to grasp and release objects by 6-9 months	☐	☐
23) Child is unable to grasp objects using thumb and index finger by 12 months	☐	☐
24) Child has movement difficulties and lacks awareness of / neglects a limb at 12 months	☐	☐
25) Child is unable to manipulate small objects by 3 years of age	☐	☐
26) Child is unable to feed with finger or spoon by 18 months	☐	☐
27) Child is unable to drink from a cup by 2 years	☐	☐
28) Child is unable to pull clothes on / up by 3 years	☐	☐
29) Child is unable to sit in a chair unsupported by 3 years	☐	☐
30) Child is likely to require additional support when they start school	☐	☐

Any other information / concerns or observations to support your referral please add

Does the child have MECHANICAL SWALLOWING DIFFICULTIES ? You will need to have observed the child eating and drinking **YES / NO**

If yes please complete the following:

Indicators of concern	Tick yes	/ no
31) Child displays uncoordinated swallow resulting in coughing or choking	☐	☐
32) Child displays repeated throat clearance, eye watering or facial reddening at mealtimes	☐	☐
33) Child displays wheezing or "gurgly" sounds around mealtime	☐	☐
34) Child has a history of failure to thrive, chest infections or may be having treatment for asthma or cyanotic episodes	☐	☐

If the child is vomiting and refusing food please refer to GP or Hospital Paediatrician for medical investigation or support to manage gastro oesophageal reflux.

If the child requires support for weaning or can manage a range of foods but prefers to eat a limited range of tastes please refer to Health Visitor / School Health Advisor as these are unlikely to be mechanical issues.

PEN PORTRAIT ; for **REFERRER** please describe the child's strengths and challenges they face. What is the impact on their daily lives at nursery / pre school and at home?

What has the referrer already done to manage these difficulties? What has not worked so well?

Any other information / concerns or observations to support your referral please add here or on a separate sheet

Return referral to: Referrals, Child Development Centre, Sandy Lane, Warrington, WA2 9HY

Phone number: 01925 867867

OFFICE USE ONLY

Date presented to under 4s Complex Care Panel: _____
Decision: Accept / Return to referrer /Other

Action	By whom	By when
1		
2		
3		
4		
5		

Signed: _____

Actions to be reviewed by _____ on _____ date