

Evelina London Community Children’s Services

Specialist Services Referral Form

Use this form for referral to Community Paediatricians, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Complex Needs Nursing

Please give as much information as possible. This will help us to process your referral quickly and appropriately. If information is not complete we will not be able to accept the referral.

Please attach any additional information on a separate sheet.

Please indicate (x) the service(s) you think this child needs:

|  |  |  |  |
| --- | --- | --- | --- |
| Community Paediatrician  | [ ]  | Speech and Language Therapy | [ ]  |
| Physiotherapy | [ ]  | Complex Needs Nursing | [ ]  |
| Occupational Therapy | [ ]  | Continuing Care Nursing | [ ]  |

To ensure the best possible assessment for the child, we may contact colleagues in other parts of the health service as well as professionals in Social Care, Education and other relevant agencies to seek their input. Based on the information received we may refer your child to other services or prioritise services. Please check this box to indicate that this has been explained to the parent / carer [ ]

|  |  |  |
| --- | --- | --- |
| NHS No:       | Date of Birth: | M[ ] /F[ ]  |
| Child’s first name:  | Family name:  |
| Parent/Carer(s) name(s):       | Relationship to child:       |
| Address:       |
| Post Code:       | Telephone home:       | mobile      |
| Email address:      |
| School/Nursery:      |
| GP:      | GP address:      |
| HV/SN:      | HV/SN Base:      |

Ethnicity (please check as appropriate)

|  |  |  |
| --- | --- | --- |
| WHITE  | ASIAN OR ASIAN BRITISH | OTHER ETHNIC GROUPS |
| British | [ ]  | Indian | [ ]  | Chinese | [ ]  |
| Irish | [ ]  | Pakistani | [ ]  | Any other ethnic group | [ ]  |
| Any other white background | [ ]  | Bangladeshi | [ ]  | Not Stated | [ ]  |
|  | Any other Asian background | [ ]  |  |
| MIXED |  |  |
| White and Black Caribbean | [ ]  | BLACK OR BLACK BRITISH |  |
| White and Black African | [ ]  | Caribbean | [ ]  |  |
| White and Asian | [ ]  | African | [ ]  |  |
| Any other mixed background | [ ]  | Any other black background | [ ]  |  |

Reason for Referral

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| Urgent? No [ ]  Yes [ ]  : Please describe why        |
| **Please give details of what parent/carer and child are expecting from this referral:**      |

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| Background/Additional InformationAny relevant history: e.g. pregnancy and birth, family health and social history, medical information etc. |
|       |
| Current Medication (attach list if available)       |
| Does the child have a hearing impairment? Yes[ ]  No[ ]  Date of recent hearing assessment     Does your child have end of life care? Yes[ ]  No[ ] Does your child have home ventilation? Yes[ ]  No[ ] Does your child have a tracheostomy? Yes[ ]  No[ ] If applicable, indicate stage on Code of Practice: School Action, School Action Plus, EY action, EY action plus, EHCPlan (please attach latest IEP/psychologist report). |
| Other agencies involved: Audiology [ ]  ENT [ ]  Social Service [ ]  SEN[ ]  Other [ ]  Please give details of other professionals involved:       |
| Are there any safeguarding issues?       |
| Is this child a ‘looked after child’? Yes [ ]  No [ ]  Does the child have a child protection plan? Yes [ ]  No [ ] Does the child have a child in need plan? Yes [ ]  No [ ] Does the family have an allocated Social worker? Yes [ ]  No [ ] If yes please give details: |
| Name:      | Contact Number:       |
| Email:      Address:       |
| Is an interpreter needed for the assessment? Yes[ ] /No[ ]  If yes, in which Language       |
| If there is likely to be a problem with attendance, please indicate any support that might be helpful: |
| Please describe how the child’s difficulties are affecting their everyday life.**Movement and** **mobility:** sitting, standing, walking, balance and co-ordination.       |
| **Self-care skills:** dressing, bathing, toileting, feeding, organising self, independence.       |
| **Communication:** speech sounds, understanding instructions, vocabulary, fluency, non-verbal.      |
| **School tasks:** writing, using scissors, participation in PE, maintaining attention, academic progress.      |
| **Play skills:** interest in toys, turn taking, playing with peers, role play and imagination.      |
| **Behaviour:** friendships, interests, changes in routine, aggression, activity level, impulsivity, mood, focus on toys/play/school work.      |

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| **Consent:**Has informed consent been obtained for the child to be referred? Yes[ ] /No[ ]  Date:       |

|  |  |
| --- | --- |
| **Name of Referrer:** | **Date of referral:** |
| **Designation:**  | **Tel no.:** |
| **Email address:** |
| **Contact Address:** |

Once completed please send this form, together with any relevant reports or letters to:

**Email address:****gst-tr.evelinacommunityreferrals@nhs.net**

Please ensure **an electronic referral is sent via a secure email** connection e.g. nhs.net account.

*Otherwise please send* ***hard copy*** *to the relevant numbers/addresses below:*

***LAMBETH:***

***Referrals Team Tel: 020 3049 4005***

***Evelina London Community Children’s Services***

***Mary Sheridan Centre***

***5 Dugard Way***

***London***

***SE11 4TH***

***SOUTHWARK:***

***Referrals Team, Tel: 020 3049 8029***

***Evelina London Community Children’s Services,***

***Sunshine House,***

***27 Peckham Road,***

***London***

***SE5 8UH***

**It is the referrer's responsibility to check that the referral has been received by the service. If an automatic email has not been generated, following submission of a referral by email, then please contact the service**