Please complete this referral form if you would like to make a referral to any of the following teams: Speech and Language Therapy, Occupational Therapy, Physiotherapy, Dietetics.

Please note: Each section is essential and needs to be completed in full (appendices to be completed as appropriate to the referral). Incomplete forms will be automatically rejected and returned.

|  |  |  |  |
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| **Please indicate the profession(s) you are referring the child/young person to and complete the relevant appendice as indicated** | | | |
| Speech and Language Therapy | ❑ (Appendix 1) | Physiotherapy | ❑ (Appendix 3) |
| Occupational Therapy | ❑ (Appendix 2) | Dietetics  (Please note that dietetics **ONLY** accept referrals from Health, Education and Social Care professionals. **NO SELF REFERRALS**) | ❑ (Appendix 4) |

|  |  |  |  |  |  |  |  |  |  |  |
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| **Child’s Details (BLOCK CAPITALS)** | | | | | | | | | | |
| Surname: | | | | First name: | | | | DOB: | | |
| Gender: | | | | Ethnicity: | | | | NHS no (if known): | | |
| Parent/carer names: | | | | 🕿 Home: | | | | 🕿 Mobile: | | |
| Parent/carer email address: | | | | | | | | | | |
| Can the family access virtual appointments (e.g. video calls)? | | | | | | | | | YES ❑ | NO ❑ |
| Who has parental responsibility for the child? | | | | | | | | | | |
| ❑ | As above | ❑ | Other - please provide details: | | | | | | | |
| Home language: | | | | | Interpreter required: | | | | YES ❑ | NO ❑ |
| Home address:  Postcode: | | **All correspondence will be sent to this address unless otherwise indicated.** | | | | | | | | |
|  | | | | | | | | | | |
| GP name and address: | |  | | | | | | | | | |
| Health visitor / School nurse: | |  | | | | | | | | | |
| School/pre-school: | |  | | | | | | | | | |
| Class teacher/  SENCo/LSA: | |  | | | | Class/year group: |  | | | | |

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| --- | --- | --- | --- | --- | --- |
| **Please indicate which of these services are, or have been, involved with this child:** | | | | | |
| ❑ | Hospital Consultant | ❑ | Occupational Therapy | ❑ | Educational Psychology |
| ❑ | Community Paediatrician | ❑ | Physiotherapy | ❑ | Social Services |
| ❑ | Dietetics | ❑ | Speech & Language | ❑ | Health Visitor / School Nurse |
| ❑ | CAMHS | ❑ | Music Therapy |  |  |
| ❑ | Other (please specify): | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please complete for each agency currently working with the child/young person/family** | | | |
| Name of service provider | Contact Details | Length / date of treatment | Additional information / Report enclosed? |
|  |  |  |  |
|  |  |  |  |
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| --- |
| **Relevant History** |
| Please attach any relevant reports (e.g. medical, educational) and provide relevant information relating to medical / family / social history. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referrer details** | | | | | |
|  | Signature of referrer: |  | Date: |  |  |
|  | Print name: |  | Role: |  |  |
|  | Contact address: |  | | |  |
|  | Contact no: |  | | |  |
|  |  |  | | |  |

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| --- |
| **CONSENT** |

|  |  |  |  |  |  |
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| **Children under the age of 16:**  **Parent/carer consent** (Requests cannot be accepted without the consent of the parent/guardian.) | | | | | |
| *I give my consent for this request and any therapy assessments that may be required, in addition to information being shared with the appropriate statutory agencies as long as it is in the best interest of my child. I confirm that I understand that the information in the referral form and actions taken will added to my child’s electronic healthcare records.* | | | | | |
|  | Signature of Parent/Carer |  | Date: |  |  |
|  | Print name: | | | |  |
| ❑ | Verbal consent has been obtained from parent/carer (if GP unable to get signature) | | | |  |

|  |  |  |  |  |  |  |  |
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| **Children/young people aged 16 and older:** | | | | | | | |
| **Does the person referred have the capacity to consent to this referral?** | | | | YES ❑ | | NO ❑ | |
| *PLEASE NOTE : CONSENT INFORMATION MUST BE MADE ACCESSIBLE IF THE PERSON IS UNABLE TO READ OR WRITE* | | | | | | | |
| **If YES, the young person needs to provide verbal or written consent**.  *I give my consent for this request and any therapy assessments that may be required, in addition to information being shared with the appropriate statutory agencies as long as it is in my best interests. I confirm that I understand that the information in the referral form and actions taken will be added to my electronic healthcare records.* | | | | | | | |
|  | Signature of young person: |  | Date: | |  | |  |
|  | Print name: | | | | | |  |
| ❑ | Verbal consent has been obtained from young person (if GP unable to get signature) | | | | | |  |

**Appendix 1 – Speech and Language Therapy**

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| --- | --- |
| **If referrer is school/nursery:** |  |
| Have you recently discussed this child with a Speech and Language Therapist? If yes, when? |  |
| Is this referral for a statutory assessment (NA2 advice)? |  |

|  |
| --- |
| **Reasons for requesting assessment** Please put as much information here as possible |
| What are your concerns about communication? How does the child/young person communicate right now? |
|  |
| How long have you been concerned? Why are you referring *now*? |
|  |
| What strategies have you tried already? What is in place to support the child/young person? |
|  |
| How successful have these strategies been? |
|  |
| What impact do the above concerns have on this child/young person? How do their difficulties affect them? |
|  |
| What do you hope this request for assessment will achieve? What is your top priority for Speech and Language Therapy right now? |
|  |

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| Please indicate the level of concern for this child/young person from both the school and parent(s) perspectives, for each of the areas listed below. | | | | | | | | |
|  | **No concern** | | **Mild concern** | | **Moderate concern** | | **Significant concern** | |
| Referrer | Referrer | School | Referrer | Referrer | Parent | Referrer | Parent |
| Play / social skills |  |  |  |  |  |  |  |  |
| Attention & listening |  |  |  |  |  |  |  |  |
| Understanding |  |  |  |  |  |  |  |  |
| Expressive language |  |  |  |  |  |  |  |  |
| Speech sounds (clarity) |  |  |  |  |  |  |  |  |
| Chewing / swallowing \* |  |  |  |  |  |  |  |  |
| Stammering |  |  |  |  |  |  |  |  |
| Selective mutism / reluctance to talk |  |  |  |  |  |  |  |  |

\* Please also complete section on eating and drinking below

|  |
| --- |
| **Eating and Drinking –** please only complete if you have concerns about the child’s eating and/or drinking |
| Does your child cough while eating or drinking? If so, how often?  Has your child had recurrent chest infections over the last year (3 or more)?  Does your child eat a range of different foods?  Please provide any other information or concerns around eating and/or drinking: |

|  |  |  |  |
| --- | --- | --- | --- |
| Has this child/young person received support from the speech and language therapy service previously? | | YES ❑ | NO ❑ |
| If YES, when? |  | | |

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| --- |
| Any other information: |
|  |

**Appendix 2 – Occupational Therapy**

|  |
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| What is the main functional concern that impacts on the child’s daily life? |
|  |
| What is the desired outcome as a result of this referral? |
|  |
| What strategies have already been tried to support the child? |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Has this child received support from the Occupational Therapy team previously? | | YES ❑ | NO ❑ |
| If YES, when? |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please indicate the level of concern for this child/young person from both the referrer and parent(s) perspectives, for each of the areas listed below. | | | | | | | | |
|  | **No concern** | | **Mild concern** | | **Moderate concern** | | **Significant concern** | |
| Referrer | Referrer | School | Referrer | Referrer | Parent | Referrer | Parent |
| Fine Motor /Hand skills |  |  |  |  |  |  |  |  |
| Dressing |  |  |  |  |  |  |  |  |
| Eating at Mealtimes |  |  |  |  |  |  |  |  |
| Using Cutlery |  |  |  |  |  |  |  |  |
| Using the toilet |  |  |  |  |  |  |  |  |
| Mark making/handwriting |  |  |  |  |  |  |  |  |
| Tool use – e.g. scissor skills |  |  |  |  |  |  |  |  |
| Seating |  |  |  |  |  |  |  |  |
| Attention & listening |  |  |  |  |  |  |  |  |

**Sensory Concerns**

|  |  |  |  |
| --- | --- | --- | --- |
| Please indicate if there are significant concerns with the following areas **of sensory processing that are impacting on the child’s participation in daily activities and /or development of skills** | | | |
|  | **Significant concern** | | **Please describe your concerns** |
| Referrer | Parent |
| Difficulty with textures, impacting on play and self care tasks. |  |  |  |
| Frequently mouths non-food items, impacting safety |  |  |  |
| Seeks out all types of movement, which impacts concentration to tasks and learning. |  |  |  |
| Sensitivity to noise impacting participation in activities and accessing the community. |  |  |  |

|  |
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| Any other information: |
|  |

**Appendix 3 – Physiotherapy**

If your concern is regarding flat feet, bow legs, knocked knees or intoeing gait there is no need to refer to the Physiotherapy Service.

Please see the attached link for advice and reassurance that this is a normal variant of growth.

APCP links:

<https://apcp.csp.org.uk/parent-leaflets>

|  |
| --- |
| What is the main functional concern that impacts on the child’s daily life? |
| How are the child’s movement skills affected?  i.e. pain, falling, loss of skills, delay with attainment of gross motor skills |
| What is the desired outcome as a result of this referral? |
|  |
| What strategies have already been tried to support the child? |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Has this child received support from the Physiotherapy team previously? | | YES ❑ | NO ❑ |
| If YES, when? |  | | |

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| --- |
| Any other information: |
|  |

**Appendix 4 – Dietetics**

Please note that we **ONLY** accept referrals from Health, Education and Social Care professionals. No self-referrals.

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| **Dietetics** | | | | | | |
| Weight (in kg): | | Centile: | | Date taken: | | Other measurements: |
| Length/height (in cm): | | Centile: | | Date taken: | |
| What is the main reason for the referral to dietetics? Please tick all applicable: | | | | | | |
| ❑ | Cow’s milk allergy (suspected non-IgE allergies **only)**  *For suspected IgE-Mediated CMPA (e.g. anaphylaxis, acute uricaria, acute angioedema, acute allergic reaction occurring within minutes to 2hrs after milk ingestion) please refer immediately to QEH/UHL allergy clinic (0208 836 5062/5073* | | | | | |
| ❑ | Selective / fussy eating | | ❑ | | Gastrointestinal problems e.g. constipation | |
| ❑ | Enteral tube feeding | | ❑ | | Micronutrient deficiencies | |
| ❑ | Faltering growth | | ❑ | | Obesity (**only** if unable to attend Xplore Greenwich) | |
| ❑ | Feeding difficulties | | ❑ | | Premature infants | |
| ❑ | Other (please specify): | | ❑ | | Food allergy | |
| Please give as much detail as possible including any previous relevant history, onset of symptoms, current medications and results of blood tests etc | | | | | | |
|  | | | | | | |
| Please provide details of any strategies or treatments that have already been tried with this child? | | | | | | |
|  | | | | | | |
| Any other information: | | | | | | |
|  | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Has this child received support from the Dietetics team previously? | | YES ❑ | NO ❑ |
| If YES, when? |  | | |