Evelina London Community Children’s Services

Specialist Services Referral Form

Use this form for referrals to Community Paediatricians, Physiotherapy, Occupational Therapy, and Speech and Language Therapy. Please attach any additional information on a separate sheet.

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| Community Paediatrician |  | Speech and Language Therapy |  |
| Physiotherapy |  | Occupational Therapy |  |

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 the child to other services or prioritise services. Please check this box to indicate that this has been explained to the parent / carer

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of referrer** |  | **Date of referral** |  |
| **Designation** |  | **Contact number** |  |
| **Email address** |  | **Contact address** |  |

**Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **NHS number:** |  | | |
| **Gender:** | **M** / **F** | **Date of birth:** |  |
| **Child’s first name:** |  | **Child’s surname:** |  |
| **Parent/ carer(s) name:** |  | **Relationship to child:** |  |
| **Address:** |  | **Postcode:** |  |
| **Telephone number:** |  | **Mobile number:** |  |
| **Email address:** |  | **School/ nursery:** |  |
| **GP Practice:** |  | **GP address:** |  |

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** | | **BLACK OR BLACK BRITISH** | |
| White and Black Caribbean |  | Caribbean |  |
| White and Black African |  | African |  |
| White and Asian |  | Any other black background |  |
| Any other mixed background |  |  | |

Reason for Referral

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

|  |  |
| --- | --- |
| Background/Additional Information  Any 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 the child have end of life care? Yes No  Does the child have home ventilation? Yes No  Does the 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 ‘Child Looked After? 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.    **For Speech & Language Referrals only** | |

**For Speech & Language referrals only**

|  |  |
| --- | --- |
| **Has a WellComm screen been completed? (Please attach to this referral)** | **Yes**  / **No** |
| **Date completed:** |  |
| **WellComm RAG rating** | **Red** |
| **Amber** |
| **Green** |

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

**Email address:**[**gst-tr.evelinacommunityreferrals@nhs.net**](mailto:gst-tr.evelinacommunityreferrals@nhs.net)

Please call **020 3049 4005** if you wish to discuss your referral

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

***LAMBETH:***

***Referrals Team***

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

***Mary Sheridan Centre***

***5 Dugard Way***

***London***

***SE11 4TH***

***SOUTHWARK:***

***Referrals Team,***

***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**