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

_____

_____

_____

_____

Urgent? No ☐ Yes ☐ : Please describe why

_____

_____

Please give details of what 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 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.

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