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**Tics and Neurodevelopmental Movements Team (TANDeM) - Referral form**

**Please note we accept referrals for:**

* **Assessment and treatment for tics, complex motor stereotypies and other genetic neurodevelopmental movement conditions.**
* **Assessment and brief psychoeducation for functional neurological disorders (but no further treatment). We require parallel referral to child’s local CAMHS for functional neurological disorder referrals.**

**All referrals to the TANDeM service are centralised and then triaged based on the information provided/needs of the child. Please ensure you complete the form fully and attach available professional reports.**

**Please note referrals are only accepted from paediatricians or senior clinicians within mental health services (e.g., consultant psychiatrist, clinical psychologist), unless they are for diagnosis and management of complex motor stereotypies in which case we accept referrals from GPs.**

**As a tertiary service, we require referrals to remain under the care of their local Paediatrician and/or local senior clinician throughout our involvement. *Estimated waiting time following a referral is currently 1 year.***

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| **SECTION 1: Patient details** |
| **Child’s first name:** |  |
| **Child’s surname:** |  |
| **D.O.B:** |  |
| **NHS no. :** |  |
| **Address:** |  |
| **Parent/s or Guardian name:** |  |
| **Parental responsibility (name and relationship):** |  |
| **Email:** |  |
| **Home/Mobile Tel no.:** |  |
| **Interpreter required?:** |  No  Yes – the language required is |
| **Any safeguarding concerns:**  |  |
| **Specialist needs:** | Is the child on a Child Protection Plan or a Child in Need?   No  Yes- please give detailsIs the child looked after (i.e. under the care of the Local Authority)?  No  Yes- please give detailsIs the child under the care of children social services for other reasons?   No  Yes- please give details |
| **GP Details:** | Name:Address:Telephone:Email: |
| **School details:** | Name:Address:Telephone:Email:Is the child attending school regularly?** Yes**** No Reason:**   **Measures in place to support school access:**  |

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| **SECTION 2: Clinical details** |
| **Reason for referral** *This must include your clinical question**Please give as much detail as possible**Please, do not just request assessment for tics as this will be rejected due to high frequency of this presentation* | **What is your clinical question?** |
| **Main medical diagnosis/es:**  | **1.****2.****3.**  |
| **Medications:** | ** No**** Yes – *please give details:***  |
| **Relevant medical history:** |  |
| **Relevant developmental history:** |  |
| **Relevant family history:***(Please include medical, neurodevelopmental and mental health history if possible)* |  |
| **Allergies and sensitivities:** | ** No**** Yes – *please give details:***  |
| **Brief movement condition history:***please outline brief history (e.g., when the movements started, how they have developed over time, what types of movements child presents with, etc.)* |  |

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| **SECTION 3: Local professionals involved** |
| **Profession** | **Name and contact details**  | **Currently involved** |
| ** Paediatrician** (child must remain under a local paediatrician) | **Name:****Address:****Telephone:****Email:** | ** Yes**** No**  |
| ** Psychiatrist/Psychologist/CAMHS** | **Name:****Address:****Telephone:****Email:** | ** Yes**** No** |
| ** Other** | **Name:****Address:****Telephone:****Email** | ** Yes**** No** |

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| **SECTION 4: Consent**  |
| **Has the referring clinician gained verbal consent & discussed purpose of this referral with the child/parents?** | ** Yes**** No Reason …………………………………………………………………………….** |

**Additional comments**

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**Referrers contact details**

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| **Signed** |  | **Telephone** |  |
| **Name** |  | **Address** |  |
| **Designation** |  |
| **Date** |  | **Email**  |  |
| **Confirmation of shared care agreement:** | ** Yes**** No Reason …………………………………………………………………………….** |
| **If an an out of area referral, has commission been agreed?:** | ** Yes**** No Reason …………………………………………………………………………….** |
| **If the referral if for assessment of functional movement disorder, has parallel referral been made to child’s local CAMHS?:** | ** Yes**** No Reason …………………………………………………………………………….** |

**Please complete and return with attached relevant reports to:**

***The TANDeM Service, Floor 2, Becket House, Evelina London Children’s Hospital, St Thomas’ Hospital, Westminster Bridge Rd, London SE1 7EH or email completed form to*** gst-tr.ELCHPaedNeuroReferrals@nhs.net

**Please note incomplete forms may be rejected**