**Community Paediatric Services**

**Please email your completed referral form to email address as below**

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| **Paediatrician Luton Locality**  [**Edwinlobocomms.s1@nhs.net**](mailto:Edwinlobocomms.s1@nhs.net) |  | **Paediatrician Bedford Locality**  [**ccs.beds.cdcspa@nhs.net**](mailto:ccs.beds.cdcspa@nhs.net) |  |

**Please complete this form with as much information as possible. Completion of all fields marked with \* are mandatory. The decision to accept or reject this referral and to help us establish which service/s are most appropriate will be based on the information provided. A referral containing incomplete information will be returned and lead to a delay in the referral process.**

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| **We DO NOT accept referrals for the following:** |
| * Mental health needs, anxiety, depression, self-harming, suicidal thoughts: **Please refer to CHUMS or CAMHS** * Isolated Selective Mutism: Please refer to the website SIMRA for information: [www.selectivemutism.org.uk](http://www.selectivemutism.org.uk/) * Growth concerns: **Please refer to Bedfordshire Hospitals NHS Foundation Trust** * Dyslexia: **Please liaise with schools** * Sensory Processing difficulties specifically: Please also see the online presentation and resources for information at [www.cambscommunityservices.nhs.uk/sensory-processing-awareness-training](http://www.cambscommunityservices.nhs.uk/sensory-processing-awareness-training) * Young people aged 13+ for assessment for possible Autism Spectrum Disorder: **Please refer to CAMHS -**   <https://camhs.elft.nhs.uk>   * Young people aged 17½ + for assessment for possible Autism Spectrum Disorder: **Please refer to the Adult Autism Service** - <https://www.elft.nhs.uk/service/5/Adult-Autism-Service-Bedfordshire> * Young people aged 17½ + with ADHD concerns – **Please refer to GP.** * Musculoskeletal conditions causing pain or functional issues and isolated gross motor delay to be: **Please refer to Physiotherapy -** <https://www.bedfordshirehospitals.nhs.uk/our-services/occupational-therapy-and-physiotherapy/physiotherapy-bedford-hospital/community-physiotherapy/> * Difficulties with functional skills not in line with general development and not primarily caused by sensory processing difficulties: **Please refer to** **Occupational therapy -** [www.cambscommunityservices.nhs.uk/Bedfordshire/services/occupational-therapy](http://www.cambscommunityservices.nhs.uk/Bedfordshire/services/occupational-therapy). * Speech/Language delay/difficulties: **Please refer to** **Speech and Language Service:** [www.childspeechbedfordshire.nhs.uk](http://www.childspeechbedfordshire.nhs.uk) * Concern about tics / tic disorders in children also requiring assessment Autism Spectrum Disorder (aged 13 years and over). – **Refer to CAMHS** * Children presenting with isolated tics which are having a significant impact on quality of life, or with other neurological concerns – **Refer to the Hospital** |

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| **SECTION A** | | | |
| **\*Child/Young Person’s Surname:** | **\*Forename/s:** | **Known As:** | **\*Male  Female**  **Transgender** |
| **\*Date of Birth:** | **\*NHS No.:** | **Ethnicity:** | **Religion:** |
| \***Home address:**  **\*Postcode:**  **\*Telephone No.:**  **\*Email address:**  **\*Are there any known risks/reasons why a home visit should not be undertaken? Yes  No**  **If yes, please provide further information:** | | **\*Child’s first language:**  **\*Parent(s)/carer(s) first language:**  **\*Is an interpreter or signer required? Yes  No**  **\*If yes, which service/language is required?**  **\*Do parent(s)/carer(s) have any communication difficulties/disabilities? Yes  No**  **\*If yes, please provide further information:** | |
| \***Child/Young Person’s GP Practice:**  **GP Name:**  **GP Address:**  **Has GP been informed? Yes  No** | | **\*Have you discussed this referral with the Health Visitor or School Nurse? They may be able to help the child, seeking advice from professionals, without the need for a referral. Yes  No**  **Health Visitor/School Nurse name and contact details:** | |
| **School/Early Years Setting name and contact details:**  **School/Early Years email address:**  **Days of attendance at nursery:** | | **SENDCo name and contact details:** | |

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| **\*Who has legal parental responsibility? i.e. Mother/Father/Local Authority/Joint Parent and Local Authority** | | | | | | |
| **Name** | **DOB** | **Address** | **\*Preferred Tel No.** | **\*Alternative Tel No.** | **Email Address** | **Main Carer**  Yes  No  Yes  No |
| **Other household members** | | | | | | |
| **Name** | | **DOB** | **Relationship to the child** | **If they are a sibling, are they known to community paediatric service?** | | |

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| **About the child** |
| Has the statutory notification been sent to Local Authority special education needs and disability service for children under 5?  Yes  No  If no, please state why?  Please see link below to complete the notification:  <http://www.luton.gov.uk/Education_and_learning/Special_educational_needs/SENsupport/Pages/default.aspx>  <https://cms2-centralbedfordshire.uat.jadu.net/migrated_images/send-early-years-referral-form_tcm3-30685.pdf>  <https://www.bedford.gov.uk/schools-education-and-childcare/special-educational-needs/send-team/early-years-support-team/> |
| \*Does the child have a: \*Are there any safeguarding concerns /  Team Around the Family/EHA: Yes  No  MASH referrals / MARAC reports:  Child in Need Plan: Yes  No  Yes  No  Child Protection Plan: Yes  No  Is the child a Looked After Child:  Yes  No  If the answer to any of the above questions is yes, please provide further information, including the Social Worker’s name and contact details: |

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| **Other professionals involved - Please attach copies of relevant professionals’ reports (with parental consent)** | | | | |
|  | **Current** | **Past** | **Referred** | **Name and Contact Details. Please provide information about the involvement, including dates:** |
| 0-19 Team |  |  |  |  |
| Audiologist |  |  |  |  |
| Community Continence Nurse |  |  |  |  |
| CAMHS |  |  |  |  |
| Dietician |  |  |  |  |
| Early Help Team |  |  |  |  |
| Early Years Support/SEND Team |  |  |  |  |
| Family Support Worker |  |  |  |  |
| Orthoptist |  |  |  |  |
| Occupational Therapist |  |  |  |  |
| Paediatrician |  |  |  |  |
| Physiotherapist |  |  |  |  |
| School Nurse |  |  |  |  |
| Sensory & Communication Support Team |  |  |  |  |
| Social Worker |  |  |  |  |
| Specialist Early Intervention Practitioner |  |  |  |  |
| Speech & Language Therapist |  |  |  |  |
| Other |  |  |  |  |

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| **\*SECTION B – REASONS FOR REFERRAL – please see the attached eligibility referral criteria.**  Please indicate the reason/s for referral. Where stated please complete the relevant appendix/ces as required |
| * Children with complex developmental difficulties (affecting more than one area of development) * Neurodisability or medical condition causing developmental disorder or delay e.g. Cerebral palsy   [https://www.centralbedfordshire.gov.uk/info/15/special\_educational\_needs\_and\_disability\_-\_ local\_offer/873/luton\_and\_bedfordshire\_s\_neurodevelopmental\_disorder\_ndd\_pathway](https://www.centralbedfordshire.gov.uk/info/15/special_educational_needs_and_disability_-_%20%20%20%20%20%20%20%20%20%20%20%20local_offer/873/luton_and_bedfordshire_s_neurodevelopmental_disorder_ndd_pathway)   * Possible Attention Deficit Hyperactivity Disorder (ADHD) for assessment, diagnosis and on-going medication review - Children who are 5 years old and above- **please complete all sections and appendix 1** * Possible Social Communication Difficulties/Interaction or possible autism for assessment and diagnosis - **please complete all sections and appendix 2** * Children requiring investigation for possible medical causes for significant learning disability where a learning disability has been identified by education services * Co-ordination difficulties with co-morbidity * Enuresis service (urinary incontinence) – over 5 years of age following active input from GP * Encopresis (faecal incontinence) * Concern about tics / tic disorders in children also requiring assessment for neurodevelopmental concerns such as possible Autism Spectrum Disorder (aged up to 13 years) or Attention Deficit Hyperactivity Disorder. |

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| **\*Do the child’s parent(s)/carer(s) have concerns and what are they?** | |
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| **Does the child/young person have concerns and what are they?** | |
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| **\*Does the educational setting have concerns and what are they?** | |
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| **\* Referrer’s concerns** | |
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| **\*What is your expected outcome of the assessment from Community Paediatric Service?** | |
| For soiling issues please describe what medications and behavioural strategies have already been tried, when they were tried and your child's response to the treatments | |
| **\*SECTION C - Please provide information about INTERVENTIONS AND STRATEGIES that have already been offered and taken up, and what affects these have had?** | |
| **At home** (include examples of support from Health Visitor, Family Worker, EHA, CAMHS, parenting programmes etc.): **For soiling issues please describe what medications and behavioural strategies have already been tried, when they were tried and your child's response to the treatments** | **At setting** (include examples of the support provided by specialist services/additional support in the child’s setting. Please include dates if known): |

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| **\*SECTION D – BACKGROUND HISTORY – please complete as comprehensively as possible** |
| **Birth and Medical History (including any medication and dose if known):** |
| **Developmental History (include milestones if known):** |
| **Does the child have any known diagnosis:** |
| **Relevant Family History:** |

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| **SECTION E – CURRENT FUNCTIONING AND DEVELOPMENT skills - please provide information from the home and education setting where applicable:** |
| **\*Motor skills:** |
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| **\*Self-care/independence skills:** |
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| **\*Communication skills, including social interaction, how the child communicate, listening and attention, understanding, speaking:**  Note if your referral is for suspected ASD you can put this information in the SCDQ which needs to be completed and submitted with this referral form. |
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| **\*Personal, emotional and social development that cause concern, (managing feelings and behaviour, self-confidence and awareness, making relationships):** |
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| **\*Behaviour/s that cause concern(Behaviours, sleep problems & sensory needs that cause concern):** |
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| **RELEVANT EDUCATIONAL INFORMATION, identifying current levels of attainment:** |
| **e.g. Please provide details of scores within ASQ, Early Years Foundation Stage Development Matters, National Curriculum or other:**  This could include SEND Support Plan, Individual Education Plan (IEP), Sleep Diaries, Intake / Outtake reports for Enuresis/Encopresis, Dyslexia Reports, private provider, reports from overseas / other paediatricians if moved into area, translated documents, ABC Movements forms.    **Has the child had an assessment by an Educational Psychologist (EP)? Yes  No**  *(If the child/young person has been seen by EP, please attach report)*  **Does the child have an Education, Health and Care Plan? Yes  No  Requested** |
| **Any other relevant information** |
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| **\*CONSENT:** |
| I confirm that a person with parental responsibility has given their consent for this referral: Yes  No  I confirm that a person with parental responsibility has given their consent to enable information to be shared and discussed with appropriate professionals, services and/or multidisciplinary agencies: Yes  No  Cambridgeshire Community Services NHS Trust is committed to open working and efficiency in providing services. To ensure that services are as tailor made as possible to the requirements of its patients the Trust recognises that with advancing technology, current communication may not be convenient or possible with some patients. To this end the Trust will be willing to undertake email correspondence  The patient/parent/carer understands that the Trust has no responsibility for information that leaves authorised NHS (National Health Service) network at the request of the patient and as such cannot guarantee the security of such information. By signing below the parent/carer indicates they have read and understood the conditions given above.  I give consent for you to share any relevant information for my child with their school (*specify School here*).  The parent/carer also understands they are able to review or cancel this arrangement at any time in writing  I confirm that a person with parental responsibility has given their consent for Community Paediatric team to contact them via their email address with information that isconfidential: Yes  No  I confirm that a person with parental responsibility has given their consent for Community Paediatric team to contact the School via email address with information that isconfidential: Yes  No  Date referral discussed with parents/carers:  I confirm that all the details in this referral are correct  Signed/Electronic signature:  Print Name: Role:  Full postal address:  Postcode:  Telephone number (s): Email address: |

**Appendix 1 – School Report**

Further information is required which will help with assessment. This can include referrals for possible Attention Deficit Hyperactivity Disorder (ADHD) for assessment, advice, signposting, diagnosis and on-going medication review where appropriate.

Children who are 5 years old and above.

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**Please email the relevant service with patient’s name and date of birth to obtain link for Connors questionnaire**

**Appendix 2 – Social Communications Difficulties Questionnaire (SCDQ)**

Additional Information to be completed for referrals for possible Social Communication Difficulties/Interaction for assessment, advice, signposting, diagnosis which includes possible Autistic Spectrum Disorder (ASD) Please complete one of the forms below as age appropriate.

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**Preschool children School age children/young people**

**Bedfordshire Community Paediatrics ONLY: Please email the service with patient’s name and date of birth to obtain link for ASRS questionnaires**