**Community Paediatric Physiotherapy Referral Form**

*Please complete this form in block capitals/typed*

**(Please note: Incomplete referral will not be processed)**

**We are not commissioned as a musculoskeletal service and all referrals of this nature should be referred via your GP to the musculoskeletal services at Addenbrookes or Hinchingbrooke hospitals.**

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| **Name:** | **Date of Birth:** | **Gender:** Male/ Female |
| **Address:** | **Phone:****Home:****Mobile:** |
| **GP:** | **NHS number:**: |
| **School (**if applicable)**Does the child have an EHC plan/statement?** (please outline support provided) |
| **Consent to receive SMS text for appointment reminder Yes / No** |

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| **Reason for referral** (presenting condition): |
| **Diagnosis** (if known): |
| **History of presenting condition** (including parental/school concerns): |
| **Has the child received physiotherapy input in the past: Yes / No**If yes, detail where, who and advice given: |
| **What interventions (related to this issue)** have been tried in the past or are currently taking place and who is providing them? |
| **Previous physiotherapy strategies and advice adhered to:** |
| **Past medical history:** |
| **Social History** (including home situation, cultural, social): |
| **Any other relevant information** (play and leisure activities; child protection issues, translation requirement etc): |
| **Other professionals involved (tick if applicable and give contact details):**Speech and Language Therapy / Occupational Therapy / Health Visitor / Paediatrician / Social Work Educational psychologist / Other**Are you making a referral to any other service at the same time as this referral?** |
| **Referrer’s name, contact detail and telephone number:** **Date:** |

 **Please return this form with any available reports to:**

*Postal address:* Children’s Therapy Services*,* The Peacock Centre*,* Brookfields Hospital Campus

Mill Road, Cambridge CB1 3DF Tel: 01223 218065

*Email address:* CCS-TR.therapyreferrals@nhs.net