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| PAEDIATRIC THERAPY REFERRAL FORM - COMMUNITY SERVICES |

**\*Please note that referrals will not be accepted (and will be returned) if information on this form is not complete.**

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| **Tick one box per referral** | | | | | | |
| **Early Years**  **Speech and Language Therapy** | **Speech and Language Therapy**  **Hearing impaired service** | **Occupational Therapy and Physiotherapy** | **Speech and Language Feeding and Swallowing** | **Dietetics** | **Early Years Occupational Therapy and Speech and Language Therapy** | **Multidisciplinary Occupational therapy/Physiotherapy /Speech and language therapy** |
|  |  |  |  |  |  |  |
| **Form A** | **Form B** | **Form C** | **Form D** | **Form E** | **Form F** | **Form G** |

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| **Referrer Name**  **(please print)** |  | **Contact Number** |  |
| **Signature & designation** |  | **Contact Address** |  |

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| **Name**  **(First name then surname)** |  | **DoB** |  |
| **Gender** |  |
| **Address** |  | **Home tel no** |  |
| **Mobile tel no** |  |
| **Email address** |  |
| **Languages spoken** |  | **Ethnicity (codes below)** |  |
| **Preschool/school**  **Address**  **Contact No**  **(if attending)** |  | **GP’s name (if applicable)** |  |
| **Parent(s)/Carer(s)Name(s)** |  | **GP surgery** |  |
| **NHS No (if known)** |  | **0-19 team base**  **(if known)** |  |
| **RIO No (if known)** |  | **Referral date** |  |
| **Details of any other professionals involved** |  | **Details of any known medical diagnosis/ syndrome/additional needs** |  |
| **Has this referral been discussed and agreed with the parents/carers?** | **Yes**  **No** | **Disability** | Does the carer/child have any disability or impairment that prevents access to the service or treatments? If yes, please specify below. |

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| **Ethnicity** – please circle/highlight | | | | | |
| **Code** | **Code Description** | **Code** | **Code description** | **Code** | **Code description** |
| **A** | White – British | **G** | Mixed - Any Other | **N** | African |
| **B** | White – Irish | **H** | Indian | **P** | Any other black background |
| **C** | White - Any Other | **J** | Pakistani | **R** | Chinese |
| **D** | Mixed - White & Black Caribbean | **K** | Bangladeshi | **S** | Any other ethnic group |
| **E** | Mixed - White & Black African | **L** | Any other Asian background | **Z** | Not stated |
| **F** | Mixed - White & Asian | **M** | Caribbean |  |  |

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| **A referral acknowledgement letter or parent questionnaire will be sent out following receipt of this referral. If this has not been received in 3 weeks of sending the referral, please contact the Clinical Navigator on 01372 384 305**  **\*Please send completed referral form by fax (020 8394 3863) or email** ([CSH.Referrals@nhs.net](mailto:CSH.Referrals@nhs.net)) |

**Guidelines**

**How to fill in the referral electronically**

* Fill in the administrative details as required
* **Ticking** - If ticking in a box you can do the following – select a tick from “symbols” on the tool bar, or mark with an X
* **Highlighting** - To highlight, you can make the lettering **bold**, colour it or use an underline. This is found by clicking on the right button of the mouse (or use the toolbar) and there are the options for B for bold, a pencil drawing for colour or using the u on the toolbar above. If choices are available, you can delete the other options
* Email or Fax to the address attached to the accompanying forms

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| PAEDIATRIC THERAPY REFERRAL FORM - COMMUNITY SERVICES **Form A – Early Years Speech and Language Therapy service** |

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| **\*** The following information will help to decide what will be the right type of assessment for the child.  **Please fill in all boxes. An incomplete form may be returned to you.** |

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| **Child’s Name** |  | **DoB** |  |

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| **What is main concern?**  Why are you referring now? Give examples of the impact of your concerns on the child’s everyday life: |

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| **Clinical Factors** (please tick as appropriate) | **Yes** | **No** |
| Does anyone else in the family have speech, language or communication difficulties?  If yes, please explain: |  |  |
| Does the child have a history of hearing difficulties?  Date and result of last hearing test: |  |  |
| Does the child require a feeding and swallowing referral? (if ‘yes’ please fill in separate form) |  |  |
| Did the child walk by 12 months?  If no, when? |  |  |
| Do you have any current concerns about the child’s gross or fine motor skills, balance or coordination?  If yes, what? |  |  |
| Do you have concerns regarding the child’s general learning skills? |  |  |
| Do you have concerns regarding the child’s social interaction skills? |  |  |
| **Speech, Language and Communication** | **Yes** | **No** |
| Does the child make meaningful/appropriate eye contact? |  |  |
| Does the child respond consistently to his/her name? |  |  |
| Does the child have a strong own agenda and find it difficult to follow adult direction? |  |  |
| Does the child share joint attention and focus on age appropriate activities with adult support? |  |  |
| Does the child try to engage with you or other children verbally or non verbally? |  |  |
| Does the child point to indicate need/want? |  |  |
| Does the child play happily alongside his/her peers and watch what others are doing? |  |  |
| Does the child join in with group activities, eg singing songs, circle time? |  |  |
| Does the child follow the routine and rules in their preschool setting most of the time? (if attending) |  |  |
| Does the child show interest in a range of different toys? |  |  |
| Does the child continue to mouth toys? |  |  |
| Does the child use ‘small world’ toys and real objects appropriately, eg brushing doll’s hair, feeding teddy, ‘talking’ on the phone, making noises for animals/transport? |  |  |
| Does the child engage in repetitive play or become stuck in the way they use toys? |  |  |
| Do you have any concerns about the child’s behaviour?  If yes, please explain: |  |  |
| Does the child understand simple spoken instructions (without gesture clues)? (eg show/give me the ball) |  |  |
| Does the child show an understanding of action words? (eg make teddy jump, make dolly eat) |  |  |
| Does the child follow instructions containing two key words consistently? (eg where are the horse and the duck? Put the teddy in the box) **\*This excludes familiar instructions, eg where are your shoes?\*** |  |  |
| Does the child follow instructions containing three key words consistently? (eg put the biscuit on teddy’s plate, give me the cow, the pig and the dog)**\* This excludes familiar instructions\*** |  |  |
| Does the child respond appropriately to conversational questions? (eg what are you doing? who is that?) |  |  |

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|  | **Yes** | **No** |
| Does the child babble? |  |  |
| Does the child attempt to say any words?  If yes, approximately how many: |  |  |
| Does the child string two key words together on most occasions? (eg daddy’s car, more biscuit, baby crying) |  |  |
| Does the child string three key words together on most occasions? (eg man eating apple, mum washing car) |  |  |
| Are the child attempts at words/sentences recognisable to:  Familiar adults?  Unfamiliar adults? |  |  |
| Does the child have difficulty making some speech sounds? If so, which ones? |  |  |
| Does the child stammer/stutter? |  |  |

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| **What strategies/approaches/targets have been put in place to support the child?** |

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| **Child’s nearest clinic** (circle/highlight as appropriate) | | | **Date Referral Sent:** |
| Bourne Hall, Ewell | Emberbrook, Thames Ditton | Molesey |  |
| Dorking | Leatherhead | Tattenham |

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| **Referrer Signature** |  | **Contact Number** |  |
| **Name & designation** |  | **Contact Address** |  |

**Please send completed referral forms to**

**CSH Surrey’s Referral Management Centre** by Fax 020 8394 3863 / email [CSH.Referrals@nhs.net](mailto:CSH.Referrals@nhs.net).

For further information Tel: 020 8394 3868, Website: www.cshsurrey.co.uk