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| **Section 1** | | | **Child / Young Person’s Details** | | | | | | | | | | | | | | | | | | | | | | | | |
| Child’s Name: | | | | (Surname) | | | | | | (First Name) | | | | | | M  F | | | | | Date of Birth: | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | School / Nursery / College: | | | | | | |
| Postcode: | | | | | | | | | Parents Mobile: | | | | | | | | | | | | Language: | | | | | | |
| Home Telephone: | | | | | | | | | Child’s Mobile: | | | | | | | | | | | | Interpreter required:  Yes  No | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | Religion: | | | | | | |
| NHS Number: | | | | | | | | | | | | | | | | | | | | | Ethnicity: | | | | | | |
| GP Name: | | | | | | | | | | | | | | | | | | | | | Nationality: | | | | | | |
| GP Address / Surgery: | | | | | | | | | | | | | | | Subject to Child Protection Plan / Child In Need: Y  N | | | | | | | | | | | | |
| LAC Status: | | | | | | | | | | | | |
| **Section 2** | | | **Please tick the boxes below to indicate the services you would like this referral to be passed:** | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Paediatrician | | | | | | | Occupational Therapy | | | | | | | | | | Physiotherapy | | | | | | | | | | |
| **Section 3** | | | **Person Making Referral:** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | |  | | | | | | | | | | Address |  | | | | | | | | | | | | | |
| Job Title | | |  | | | | | | | | | |
| Telephone | | |  | | | | | | | | | |
| Email | | |  | | | | | | | | | |
| **Section 4** | | | **Parent or Carer’s Details** | | | | | | | | | | | | | | | | | | | | | | | | |
| Who has parental responsibility? | | | | | | | | | | | | | | | | | | | Interpreter required:  Yes  No | | | | | | | | |
| Parent / Carer’s Name: | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | | |
| Address:  Postcode: | | | | | | | | | | | | | | | | | | | Telephone: | | | | | | | | |
| Mobile: | | | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 5** | | | **Please tick the boxes below to indicate other Professionals / Agencies involved, if known:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Social Worker | | | | | | | | |  | | Nursery | | | | | | | | | |  | Educational Psychologist | | | | | |
|  | Court | | | | | | | | |  | | Police | | | | | | | | | |  | Educational Welfare Officer | | | | | |
|  | Health Visitor | | | | | | | | |  | | SENCo | | | | | | | | | |  | Hospital/Community Doctor | | | | | |
|  | CAMHS | | | | | | | | |  | | Youth Offending Service | | | | | | | | | |  | Children With Disabilities Team | | | | | |
|  | Early Intervention | | | | | | | | |  | | Child Development & Play Advisor | | | | | | | | | |  | Other (specify) | | | | | |
|  | Other (specify): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 6** | | | **Known Diagnosed Medical Conditions:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 7** | | | **Reason for referral and explanation of concerns including specific functional, sensory, motor difficulties, health, developmental milestones, mental health or social needs or any identified risks (Please attach relevant reports eg school), if known and any other interventions already tried:** | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 7** | | | **Medical Information (ie birth history, current health issues, medication, admission/discharge details, allergies, feeding related coughing, choking, vomiting, chest infection), if known. Attach relevant medical / other reports:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Complete where relevant (eg eating disorders or food refusal/aversion):** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height: | |  | | | | Weight: | | | | |  | | | | BP: | | |  | | | | | | Pulse: | | |  |
| **Section 8** | | | **Developmental History and Milestones:** | | | | | | | | | | | | | | | | | | | | | | | | |
| Age of smiling: | | | | |  | | | Age of sitting: | | | | | | |  | | | | | Date of hearing test: | | | | | |  | |
| Age of walking: | | | | |  | | | Age of first words: | | | | | | |  | | | | | Date of eye test: | | | | | |  | |
| Communication: | | | | |  | | | Behaviour: | | | | | | |  | | | | | Social skills: | | | | | |  | |
| Eating difficulties | | | | |  | | | Sensory behaviours | | | | | | |  | | | | | Other | | | | | |  | |
| Comments (including other milestones): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 9** | | | **Parent’s/Carer’s concerns and expectations / History of difficulties (date of onset, are the symptoms stable or worsening, what was tried/what has worked so far) / Impact of the difficulties on the young person and family:** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 10** | | | **Family History (including family composition, support network, others with illness or disability in the family, family history of mental health / substance misuse) and if other siblings are known to child health services:** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 11** | | | **Social History (including any child protection concerns) / Background Information (family difficulties, bereavement, parental illness or separation, change of home or school):** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 12** | | | **Other relevant information (including mental health concerns):** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 13** | | | **Information Sharing And Consent:** | | | | | | | | | | | | | | | | | | | | | | | | |
| Information about your child may be shared with other teams and agencies (eg Education services, Children’s Centres and social care) in order to identify the most appropriate support for your child.  Has the referral been discussed with the parent or carer?  **Yes  No**  Has the referral been discussed with the child or young person?  **Yes  No**  Is there parental consent for enquiry/onward referral to other agencies?  **Yes  No**    **Comments (if any):**  **DETAILS OF REFERRER:**  **Verbal (Parent/Carer)       Name:**  **Signed (Referrer):**  **Name:**  **Email:**   **Tel No:**  **Relationship:**  **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Office Use Only** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|
| Name and designation of receiver: | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | |
| Passed to: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Please note: **Please type or write clearly in black ink ensuring all sections are completed as fully as possible.**

**The form must be signed and at least one contact number supplied.**

**We will contact you if this referral form is not fully completed and/or we require more detail in order for us to be able to process and accept the referral.**

**T:**0300 1310 111     [**www.provide.org.uk**](https://gbr01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.provide.org.uk%2F&data=05%7C01%7Cdeborah.knight16%40nhs.net%7Cefee2787dd294240195c08daff74b7ee%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638103174006308027%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ZWAYDQyZ8fRwI7QvI%2FpCKzdZ1FIZtd9Z2WfN2Lt6MD0%3D&reserved=0)

**E (Provide Referrals):** [provide.ccc@nhs.net](mailto:provide.ccc@nhs.net)  |  **E (General Enquiries):** [provide.askus@nhs.net](mailto:provide.askus@nhs.net)