**Telephone: 0300 1310 111 Email:** provide.ccc@nhs.net

**Please note referrals to this service are for children and young people aged 0-19 years (or 18 years if not in full-time education) where there are concerns around gross motor development or altered neurology. We are unable to accept referrals for acute musculoskeletal (MSK) injuries, acute flare-ups of known MSK conditions or other MSK presentations where there are no additional developmental or neurological concerns/conditions present.**

**If the referral meets one of the latter criteria, please complete Provide Physiotherapy Outpatients referral form.**

|  |  |
| --- | --- |
| Date of Referral:       | NHS Number:       |

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| **Patient Details** |
| Forename:       | Surname:       |
| Address and Postcode:       |
| Date of Birth:       | Gender:       |
| Home Telephone:       | Mobile Telephone:       |
| Ethnicity:  |

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| --- | --- | --- |
| Learning disability [ ]   | Physical impairment [ ]   | Sensory impairment [ ]   |
| Mental Health condition [ ]   | Longstanding illness [ ]   | Other [ ]   |
| Additional Information:       |

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| **GP Details** |
| Registered GP:       | Telephone:       |
| GP Practice or F Code:       |  |

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| Has Parent/Carer given consent for this referral | Yes [ ]  | No [ ]  |

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| **Family Information** |
| Name of Parent/Carers (with parental responsibility) |       |
| Name and Age of Siblings: |       |
| Child Protection Register | Yes [ ]   | No [ ]   | Looked After Child | Yes [ ]   | No [ ]   |
| Is the child/young person known to Social Care?  | Yes [ ]  | No [ ]   | If Yes please detail:       |
| Are there any concerns surrounding the mental health of the child/young person? | Yes [ ]  | No [ ]   | If Yes please detail:       |
|  |
| **Reasons for Referral**  |
| Diagnosis (if known) or identified areas of difficulty for which further assessment/treatment may be required and also detail any concerns about any abnormal or asymmetrical movement patterns: |
|       |
| **Duration of Symptoms/Concerns**  |
| Onset of symptoms | [ ]  0 - 2 Weeks | [ ]  2 - 8 Weeks | [ ]  More than 8 weeks |
| Date of symptom onset |       |
| **Significant Birth History**  |
| Please detail:       |
|       |
| Has the child had an MRI? | Yes [ ]  | No [ ]  | If yes, please confirm the results:       |

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| **Medical History**  |
| Major Active Problems for medical history:       |
| Current Consultation:       |
| Relevant Previous Medical History:       |
| Current Medication:       |
| Allergies and Sensitivities:       |

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| **Name of Preschool/School if known** |
|       |
| Are symptoms/concerns currently affecting participation in pre-school/nursery, school/ college, sports or hobbies?    | Yes [ ]  | No [ ]  N/A [ ]   | If Yes please detail:       |

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| **Other Professionals Involved/Current Intervention** |
|       |

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| --- | --- | --- |
|  | **Parents/carers** | **Referrer** |
| **Level of concern** | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Scale 1-5 (1 = low, 5 = high)Please tick | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

|  |  |
| --- | --- |
| **Referrer Details** (complete if not patient’s GP) | [ ]  Select if patient’s GP |
| Name:       | Job Role:       |
| Organisation\Service:       | Telephone:       |