NHS
Birmingham
Community Healthcare
NHS Foundation Trust

Date:

# REFERRAL FORM

## Children and Young People

Best Care
Healthy Communities

## Children and Young People

Please complete all sections of the referral form, incomplete referrals will not be accepted.

| **Child or young person being referred** | | | |
|---|---|---|---|
| Surname of Child/Young Person: | | First Name(s): | |
| Date of Birth: | NHS No.: | Male: | Female: |
| Address and Postcode: | | | |

| **Details of Parent/Carer** | | | | | |
|---|---|---|---|---|---|
| Parent/Carer's Name(s): | | | Relationship to child: | | |
| Parental Responsibility: | Mother | Yes ☐ No ☐ | Father | Yes ☐ No ☐ | |
| Address *(if different from above)*: | | | | | |
| Daytime Contact Number/Mobile *(please ensure this is up to date)*: | | | | | |
| Email: | | | | | |
| Consent to receipt of SMS Text reminders: Yes ☐ No ☐ | | | | | |

| **Ethnicity Category** | |
|---|---|
| Ethnicity Code *(Please see page 2 for list of codes)*: | |
| **Home Language:**<br>BCHC values multilingualism and views this as an advantage. The Trust encourages families to communicate with their children in the way which feels most natural which will include using languages used in the home environment. | **Is an Interpreter required?** Yes ☐ No ☐<br>If yes please state which language: |
| Will carers have any difficulties reading appointment letters: Yes ☐ No ☐ Don't Know ☐ | |

| **Details of School/Nursery/Playgroup** | | | **Details of G.P.** |
|---|---|---|---|
| Name of School/Nursery/Playgroup/Setting | | | Name and Practice Address and postcode: |
| a.m. | p.m | all day | |
| Telephone number: | | | |

| **Child Protection Details (if any)** | | | |
|---|---|---|---|
| Child Protection Plan: | Yes ☐ | No ☐ | Unknown ☐ |
| Is the child in the care of the Local Authority: | Yes ☐ | No ☐ | Type of care order ☐ |
| Children In Need: | | | |
| Special Guardianship Order: | | | |

| **Early Help Assessment** | | | |
|---|---|---|---|
| Early Help Assessment completed | Yes ☐ | No ☐ | Unknown ☐ |
| Early Help Assessment attached | Yes ☐ | No ☐ | |
| Integrated Support Plan/Early Help Plan/Early Support plan | Yes ☐ | No ☐ | Unknown ☐ |

**Consent/Information Sharing**

It is important to ensure that the parent/carer is aware that information detailed in referrals made to Children and Families Division Services may be shared with other health professionals and external agencies such as Education and Social Care.

Has the person with legal responsibility consented to this referral and sharing of information?

Yes ☐ **If consent has not been obtained this referral cannot be accepted.**

| **Referrer Details** | |
|---|---|
| Referred by: | Signed: |
| Designation or Relationship to Child: | |
| Referrer's full contact address, postcode, telephone: | |

**Childs Name:**

**NHS Number:**

## Children and Young People

**Date**

**IMPORTANT:**
Please indicate by ticking a box below which service you are referring to. Each referral will require pages 1 and 2 of the referral form and the service specific form. If you are sending a referral to more than one service pages 1 and 2 should be sent with each referral.
**NB. A separate form needs to be completed for each service referred to.**

- ☐ Community Paediatric Service (Community Paediatricians)
- ☐ ADHD Team (for new referrals for ADHD assessment)
- ☐ Children's Speech and Language Therapy
  **Please indicate:** Communication ☐ Eating, Drinking & Swallowing ☐
- ☐ Children's Physiotherapy
- ☐ Children's Occupational Therapy Service
- ☐ Community Children's Nursing and Palliative Care Service
- ☐ Children's Nutrition and Dietetic Service

**IMPORTANT -** is the child currently being seen by or has been referred to:

| Professional | Name | Contact Tel No | Base |
|---|---|---|---|
| Health Visitor | | | |
| Social Worker | | | |
| Medical Consultant | | | |
| Other (Health, Education, Social) | | | |

**Are there any safety/security issues involved in seeing this client?**

No ☐ Yes ☐ If YES, what?

| Code | Ethnicity | Code | Ethnicity |
|---|---|---|---|
| A | White British | L | Asian/Asian British Other Background |
| B | White Irish | M | Black/Black British Caribbean |
| C | White/Other White Background | N | Black/Black British African |
| D | Mixed White and Black Caribbean | NKN | Not Known |
| E | Mixed White and Black African | NS | Not Specified |
| F | Mixed White and Black Asian | P | Black/Black British Other |
| G | Mixed Other Background | R | Other Ethnic Groups Chinese |
| H | Asian/Asian British Indian | S | Any Other Ethnic Group |
| J | Asian/Asian British Pakistani | T | Eastern European |
| K | Asian/Asian British Bangladeshi | Z | Not stated |

## Clinical Risk Identifiers

**Please tick if any of the below apply:**

- ☐ Undergoing an EHC assessment
- ☐ Risk of school exclusion
- ☐ Self harming or endangering themselves or others
- ☐ Significant decline in a deteriorating health condition
- ☐ Risk of adoption breakdown or breakdown of adoption process
- ☐ Concerns regarding change in presentation or behaviours which suggest a significant regression in skills
- ☐ Setting unable to offer child a placement due to severity of needs

**Childs Name:**

**NHS Number:**

**Community Paediatric Service**
www.bhamcommunity.nhs.uk/community-paediatrics/

# Community Paediatric Service
## (Community Paediatric Consultants)

Please enclose with pages 1 to 2 of the referral form
Each area of this form should be completed fully - incomplete forms will be returned.

**IMPORTANT:**
If you are referring due to concerns regarding behaviour that could be suggestive of **Attention Deficit Hyperactivity Disorder (ADHD)** please **refer directly to the ADHD team** using their specific referral form.

If you are referring due to concerns regarding behaviour (social and communication issues) that could be suggestive of **Autism spectrum Disorder (ASD)** please **refer directly to the Neurodevelopmental Pathway** using their specific electronic referral form **www.bchcreferrals.nhs.uk**.

**Reason for Referral:**

**Please tick the developmental areas of concern in the table and give details below:**

| Developmental Areas | No Concerns | Some Concern | Significant Concern |
|---|---|---|---|
| Motor development | | | |
| Speech and language | | | |
| Self help skills (dressing, use of cutlery, potty training) | | | |
| Behaviour and emotional wellbeing | | | |
| Learning | | | |

**Please elaborate on concerns raised above (if any):**

Community Paediatric Service

**Childs Name:**

**NHS Number:**

## Medical and Relevant Birth History:

## If other professionals involved, please attach relevant information.

i.e Pupil Support, Educational Psychologist, Therapist, Medical etc.


Telephone number:
0121 683 2320

via safe haven fax to:
0121 466 3351

via email to:
BCHNT.commchildref@nhs.net

**Childs Name:**

**NHS Number:**

# Children's Speech and Language Therapy

PLEASE ENCLOSE WITH PAGES 1 & 2 OF THE REFERRAL FORM

The SLT service works with children 0 - 18 yrs with specific Speech, Language and Communication Needs (SLCN) as well as Eating, Drinking and Swallowing difficulties. Anyone can refer to SLT and the service always works in partnership with parents / carers plus others in nursery / school. The SLT service provides information, advice / strategies and a range of interventions for children who meet the commissioned service thresholds.

Children's needs are profiled in relation to severity of impairment, impact on life, known risks as well as anticipated change in response to therapy and confirmation that others are able to provide the necessary support for the child to progress with the specialist SLT input. These factors are analysed to provide an individual profile and **only the children who meet the commissioned threshold for the service will be seen for intervention.**

It is essential that referrers provide adequate background information about the child's presenting difficulties and about the progress made to date. SLT intervention will only be effective if someone is available to carry out the communication practice in everyday interactions (e.g. family member, carer, member of staff). Incomplete referrals will not be accepted.

**The SLT service does not accept referrals for the following:** dribbling; written language difficulties (dyslexia); diagnosis of autism spectrum disorder outside of a multi-disciplinary team.

**Childs Name:**

**NHS Number:**

# Children's Speech and Language Therapy

Each area of this form should be completed fully - incomplete forms will be returned.

| **Listed below are some of the areas which can be associated with speech, language and communication (SLC) difficulties. Please detail your concerns against the areas below:** | | | |
|---|---|---|---|
| | **No Concerns** | **Some Concern** | **Significant Concern** |
| Eating, drinking and swallowing difficulties | Please detail concerns on table on next page | | |
| Understanding language, words and sentences | | | |
| Using words and sentences | | | |
| Clarity of speech / pronunciation of words | | | |
| Stammering | | | |
| Voice | | | |
| Social interaction and play (across different situations and settings) | | | |
| Attention, concentration and listening | | | |
| Learning | | | |
| Behaviour and emotional wellbeing | | | |

**What additional SLC support (strategies/advice) is already in place? How often? By whom?**
(E.g. Local Offer Graduated Response, small group work, visual timetables, signing environment etc.).
**What progress has been made?** (attach recent targets if appropriate)

**Reason for Referral:**

Children's Speech and Language Therapy

**Childs Name:**

**NHS Number:**

| **Any known medical diagnoses, developmental difficulties or allergies:** | |
|---|---|
| | |
| **Parent/Carer consent:** | |
| Signature: | Date: |
| **Has the child had Speech and Language Therapy previously (NHS or Independent)? Give details below:** | |
| | |

| | |
|---|---|
| Hearing Test? | Not known: |
| Date Carried Out: | Results: |
| Referral made: Yes ☐ No ☐ | Date if recent referral made: |
| Hearing Aids/Cochlear Implant: | |
| **What National Curriculum/EYFS/alternative levels is the child functioning at?** | |
| | |
| **What training in supporting SLCN have staff in the setting received?** (e.g. Early Language Development Programme, Language for Learning, Communication Friendly Schools Birmingham etc.) | |
| | |
| **Listed below are some of the features seen which can be associated with Eating, Drinking and Swallowing difficulties. Please detail your concerns against the areas below:** | |

| Observed when eating, drinking or swallowing? | Tick below | Comment |
|---|---|---|
| Coughing | ☐ | |
| Changes in Breathing | ☐ | |
| Changes in Colour | ☐ | |
| Eye Blinking and/or Watering | ☐ | |
| Recurrent Chest Infections | ☐ | |
| Choking | ☐ | |
| Gagging | ☐ | |
| Vomiting | ☐ | |
| Food or Fluid Refusal | ☐ | |
| Distress | ☐ | |

Children's Speech and Language Therapy

**Childs Name:**

**NHS Number:**

| Observed when eating, drinking or swallowing? | Tick below | Comment |
|---|---|---|
| Lengthy Mealtimes | ☐ | |
| Weight Loss | ☐ | |
| Dehydration | ☐ | |
| Deterioration of Eating, Drinking and Swallowing Skills | ☐ | |
| **Does the child have any alternative feeding in place e.g. NG Tube, Gastrostomy?** | | |
| Yes ☐ No ☐ | | |
| **Child ready to progress to new texture or assessment for introduction of tastes:** | | |
| Yes ☐ No ☐ | | |

For communication concerns, please send the referral form via email to:
BCHNT.cbs.slt-referrals@nhs.net

For eating, drinking and swallowing concerns, please email:
BCHNT.cbs.sltdysphagia-referrals@nhs.net

**Childs Name:**

**NHS Number:**

# Paediatric Occupational Therapy Services

PLEASE ENCLOSE WITH PAGES 1 TO 2 OF THE REFERRAL FORM

The Paediatric Occupational Therapy Service is a community based service for children and young people aged 0-18 years in the Birmingham area. The service aims to enable children and young people to participate in daily life to improve their health and well-being. Daily life is made up of many activities (or occupations).

These may include areas of self-care (getting ready to go out, eating, dressing), nursery/school activities (completing school work, following the school routine) and play/leisure skills (taking part in hobbies, playing sports)

**Who can refer?**

The Occupational Therapy service accepts referrals from health professionals, educational psychology, social workers, the Communication and Autism Team, the Physical Disabilities Support Service and Special Educational Needs Co-ordinators (SENCo)/teaching staff.

Occupational Therapy intervention will only be effective if someone is able to carry out the recommendations and advice in everyday activities, both at home and in educational settings (e.g. family member, carer, member of staff in setting).

**Please note housing adaptations and equipment needs for home should be referred directly to the Local Authority Occupational Therapy service. Please call (0121) 303 1888 or download a form from www.birminghamchildrenstrust.co.uk. On the home page, type 'occupational therapy', in the search box, to download the form. Anyone can make a referral to this service, including families.**

Requests for **wheelchairs** should be referred directly to BCHC Birmingham Wheelchair Service. The referral form can be downloaded at: **www.bhamcommunity.nhs.uk/wheelchair**

**Reason for Referral** - please tick the areas that are relevant and provide details of the **main concerns** you have in each of the areas. Describe the impact of these difficulties upon the child's activities of daily living.

Paediatric Occupational Therapy Services

**Childs Name:**

**NHS Number:**

**School Occupations:**
Recording of Work/Handwriting ☐ P.E ☐ Use of Scissors ☐
Participation in Learning ☐ Following Instructions ☐ Attention ☐

**Details:**

**Self-care Skills:**
Participating in Mealtimes ☐ Dressing ☐ Toileting ☐
Bathing ☐ Brushing Teeth/Hair ☐ Eating/Drinking ☐

**Details:**

**Play/Leisure Occupations:**
Sports ☐ Riding a Bike ☐ Taking part in Hobbies ☐ Playing in the Playground ☐
Playing Ball Games ☐ Youth Clubs/Groups ☐

**Details:**

**Sensory Processing:**
Please indicate here if you have particular concerns that sensory processing issues may be impacting on the child/young person's performance of everyday activities ☐
E.g. Self Care, School, Play or Leisure Activities.

**Details:**

**Other** ☐

**Details:**

**For Paediatricians only:**
If this referral is to contribute towards a potential diagnosis of **Developmental Coordination Disorder/ dyspraxia**, please tick the box: ☐

**NB.** Please do not refer children who are under 5 years of age for a diagnosis of Developmental Coordination Disorder (DCD). The Royal College of Occupational Therapists: Practice Briefing - November 2013, states that the onset of DCD is apparent in the early years, but the condition would not typically be diagnosed before 5 years of age.

Paediatric Occupational Therapy Services

| | |
|---|---|
| **Childs Name:** | |
| **NHS Number:** | |

**What advice has already been given and what strategies are in place?**
(E.g. fine motor/gross motor groups, previous Occupational Therapy advice sheets etc)

**What do you hope the child/young person will gain from this referral?**

**Additional Information:**
Please include diagnosis and prognosis if known, past medical history (including behavioural or communication issues), medication, referrals made to other agencies and any ongoing medical investigations or issues that may inform our assessment

**Other influences impacting on the current difficulties:**
Please describe or enclose relevant correspondence

Please send referral form via email to:
BCHNT.cbs.ot-referrals@nhs.net

| | |
|---|---|
| **Childs Name:** | |
| **NHS Number:** | |

# Paediatric Physiotherapy Service

PLEASE ENCLOSE WITH PAGES 1 TO 2 OF THE REFERRAL FORM

The Paediatric Physiotherapy Service is a community based service for children in the Birmingham area. The service aims are to:

- enable children and young people to reach their full potential;
- maximise function and independence;
- promote normal movement;
- prevent or limit contractures and deformity; and
- improve quality of life

By completing this form you are making a request for a Physiotherapy assessment. A decision to accept this referral will be made according to the nature of the impact on the child in managing activities of daily life.

Referrals will not be accepted for presentations that are normal at certain stages in a child's development e.g. Knock Knees, Bow legs or in-toeing.

**NB:** Musculo-skeletal referrals are only accepted for children up to their 14th birthday who live NORTH of the city centre. Children aged 14 years and over can be referred to the nearest hospital outpatient MSK service or to the BCHC MSK booking service: **mskbchc.referrals@nhs.net**

All Children living in the SOUTH of the city should be sent directly to their nearest hospital outpatient Paediatric Physiotherapy Department either; The Royal Orthopaedic Hospital, UHB Heartlands Hospital, or The Birmingham Women's and Children's Hospital

**Each area of this form should be completed fully - incomplete forms will be returned.**

| **Reason for Referral:**<br>Please provide details of the difficulties the child is experiencing and where they are not performing at an age appropriate level. |
|---|
| |
| **Please give details of how these difficulties impact him/her in the home?**<br>(if not already explained above) |
| |
| **Please give details of how these difficulties impact him/her in school/nursery?**<br>(if not already explained above) |
| |

Paediatric Physiotherapy Service

**Childs Name:**

**NHS Number:**

**Additional Information:**
Please include diagnosis if known, past medical history (including learning, behavioural or communication issues) and any on-going medical investigations that may inform our assessment.

**What specific support would you like from the service? What outcome do you expect for the child?**

**What strategies/interventions have been tried already?**
(E.g. Spoken to Health Visitor/activities/groups/exercises)

**Initial appointments are held in a clinic setting. If there is any reason why this might be difficult, please give details below:**

Please send referral form via email to:
BCHNT.cbs.pt-referrals@nhs.net

Community Children's Nursing and Palliative Care

**Childs Name:**

**NHS Number:**

# Community Children's Nursing and Palliative Care

Please enclose with pages 1 to 2 of the referral form

Each area of this form should be completed fully - incomplete forms will be returned.

| **Reason for Referral:** | **Referral to Consultant:** Yes ☐ No ☐ |
|---|---|
| | (if referral to consultant please state reasons) |

**Care Required:**

**Medical History** (e.g. does child have epilepsy):

**Equipment/Dressings Required:**

**Any Additional Information** (including expected date of discharge):


CCN and Palliative Care Team
Lansdowne Health Centre
34 Lansdowne Street
Winson Green
B18 7EE
Tel: 0121 245 5775
Fax: 0121 210 3333

via secure email to:
ccn.south@nhs.net

ADHD Nurse Led Service

**Childs Name:**

**NHS Number:**

# ADHD Nurse Led Service - (Attention Deficit Hyperactivity Disorder)

PLEASE ENCLOSE WITH PAGES 1 TO 2 OF THE REFERRAL FORM

Each area of this form should be completed fully - incomplete forms will be returned.

## Reason for Referral:

Current situation, please describe what is happening and when, frequency, duration – giving examples of incidents or events which are having an impact on physical health, education (school), self-esteem, emotional well-being, relationships.

## Early Developmental History/School:

Any concerns at school? Please note we only accept referrals for school aged children.

Yes ☐ No ☐

If yes, please give details:

What age were concerns first noted:

## Current Medication/Diagnosis:

Please note if aware child has a diagnosis of ADHD we are unable to accept the referral.

## Other influences impacting on the current difficulties. Please describe or enclose relevant correspondence:


Central Booking Service
Tel: 0121 683 2320

via secure email to:
BCHC.ndpadhdref@nhs.net

via email to:
BCHNT.commchildref@nhs.net

**Childs Name:**

**NHS Number:**

# Nutrition and Dietetic Service Referral Form

Please enclose with pages 1 to 2 of the referral form

Each area of this form should be completed fully - incomplete forms will be returned.

**Referral Criteria**

Please read our referral criteria on our website:
**www.bhamcommunity.nhs.uk/patients-public/adults/nutrition/childrens-nutrition-services/**
and ensure first line dietary advice has been given where appropriate

**Reason for Dietetic Input** (please tick all that apply):

Selective Eating ☐ Allergy/Intolerance ☐ Faltering Growth ☐

Nutritionally Compromised ☐ Enteral Feeding ☐ Modified Texture Diet ☐

Other ☐ Please give details:

**Priority:**

Urgent ☐ Non-urgent ☐

**Expected outcome for Dietetic Input:**
(e.g. to gain weight, to improve diet, manage food related condition, supplementary feeding etc)

**Medical Diagnosis/Condition. Please attach last clinic letter/discharge summary.**

**Relevant recent measurements** (e.g. BMI, weight, height):

**Comment on history of growth:**

Copy of growth chart attached: Yes ☐ No ☐

**Relevant medication:**

via safe haven fax to:
**0121 615 2908**

via secure email to:
referrals.nutrition@nhs.net

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