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| CHILDREN AND YOUNG PEOPLE | **Community Paediatrics Referral Form** | | Description: DCCG logo |
| Please Return to:  Anne Donkin [anne.donkin@dbh.nhs.uk](mailto:anne.donkin@dbh.nhs.uk) c/o Children's Outpatients Department  **Contact Phone No: (01302) 366666 ext 6571 Fax No: (01302) 647276** | | | |
|  | |  | |
| Name of Referrer | |  | |
| Date of Referral | |  | |
| Is this a Joint Referral? | | No | |
|  | |  | |
| **Patient Details** | | | |
| Surname: | |  | |
| First Name: | |  | |
| DOB: | | Click here to enter a date. | |
| Gender: | |  | |
| Ethnic origin: | | Choose an item. | |
| NHS Number: | |  | |
| Disability/Special Educational Need: | |  | |
| Address: | |  | |
| Interpreter required: | | No | |
| Language: | |  | |
| Looked after Child: | | No | |
| Nursery/ School/ Academy: | |  | |
| Contact: | |  | |
|  | |  | |
| **GP details** | | | |
| Name: | |  | |
| Address: | |  | |
| Tel no: | |  | |
| Fax number: | |  | |
| Is the GP aware of the referral? | | Yes | |
| Did the GP participate in the referral? | | Yes | |
|  | |  | |
|  | |  | |
| **Carer/Parent details** | |  | |
| Surname: | |  | |
| First Name: | |  | |
| Gender: | | Male | |
| Ethnic origin: | | White- British | |
| Relationship to child: | | Mother | |
| Address: | |  | |
| Tel no: | |  | |
| Interpreter required: | | No | |
|  | |  | |
| **School Nurse/Health Visitor Details** | |  | |
| Name: | |  | |
| Address: | |  | |
| Tel no: | |  | |
| Fax number: | |  | |
| Is the S/N or H/V aware of the referral? | | Yes | |
| Did the S/N or H/V participate in the referral? | | Yes | |
|  | | | |
| **Please use this referral form for the following paediatric pathways and tick the likely diagnosis (if possible)** | | | |
| 1 - Autism Spectrum | |  | |
| 2 - Attention Deficit Hyperactivity Disorder | |  | |
| 3 - Developmental Delay e.g. Language, motor concerns, co-ordination difficulties. | |  | |
| 4 - Failure to Thrive | |  | |
| 5 – Cerebral Palsy | |  | |

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| **The following information will assist in the General Development Assessment.** |
| **Please tick as appropriate if the information is attached, this can be in the form of reports, print outs of medication, letters etc. This will speed up the referral.** |

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| 1. Reason for referral & background   *Tick if attached* | | | |
| 1. Other areas of concern | | | |
| 1. Medical history | | | |
| 1. Antenatal & birth history (for Cerebral Palsy & Developmental Delay) | | | |
| 1. Developmental history | | | |
| 1. Educational issues (SN) (GP optional) | | | |
| 1. Family information | | | |
| 1. Current support the child is receiving if any | | | |
| 1. Psychology involvement if any | | | |
| **Are you aware of any issues regarding the following, please tick the relevant box and enclose the details.**  Child protection/ child in need Yes    CAF/ TAC No    Social care issues (if so please list below) Unknown | | | |
| **List of all involved (If no CAF attached)** | | | |
| Name: | Organisation: | | Contact Information (if known) |
|  |  | |  |
|  |  | |  |
|  |  | |  |
| Any other thoughts you want to capture: | | | |
| For office use only: | | | |
| Date Accepted:  Click here to enter a date. | | Name: | |