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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 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) |
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| Any other thoughts you want to capture: |
| For office use only: |
| Date Accepted:Click here to enter a date. | Name: |