Specialist Children's & Young People's Services
Child Development Service and Therapies Referral Form v2019

East London NHS
NHS Foundation Trust

Which service do you require? *(Please select)*

- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Speech & Language Therapy
- ☐ Paediatrician
- ☐ Enuresis (Bedwetting) Clinic

Details of child / young person *(please fill in all details)*

Surname		Date of birth	Male / Female *(circle)*
Forenames		Ethnicity	NHS No.
Also known as		GP details & borough (if not Newham)	
Address Postcode Telephone No.		Parent / carer names Home Language Interpreter required for Parent / Child / neither *(circle)*	
School	Year Class	Health Visitor / School Nurse	
Are there any current or previous safeguarding issues for the child / young person / family? Yes / No / Not sure *(circle)*			

Reason for referral *(please fill in all details)*

Medical Information *(please fill in all details)*

Diagnosis *(if known)* ……

Hearing / vision needs *(most recent results)* ……

Other professionals the child/young person is known to in the Community or Hospital *(please provide details)*
……

How are child's / young person's difficulties impacting on their everyday life?

Movement and mobility: (e.g. sitting, standing, walking, balancing and co-ordination)

Self-care tasks: (e.g. dressing, bathing, eating and drinking, organising self, independence)

School tasks: (e.g. writing, using scissors, participation in PE, maintaining attention)

General development, cognition and learning skills: (e.g. developmental milestones, nursery/school academic performance, learning, sleep, behaviour including sensory behaviours)

Play skills: (e.g. interest in toys, turn-taking, playing with peers, role play and imagination)

Communication and attention: (e.g. understanding spoken language, putting sentences together, social communication, unclear speech, stammer)

Eating, Drinking and Swallowing *(please select all that are relevant)*

Additional comments:

- ☐ Child has signs of difficulty when eating/drinking e.g. coughing / gagging / flushed cheeks / watery eyes / wet gurgly voice or breath
- ☐ Child has repeated chest infections
- ☐ Faltering growth/failure to thrive
- ☐ Oro-motor difficulties impacting on chewing/manipulating food in the mouth
- ☐ Does the child need the textures altering?
- ☐ Have there been changes in the child's feeding skills?
- ☐ Any difficulties sucking e.g. breast/bottle feeding?

Continence *(please select all that are relevant)*

Additional comments:

- ☐ Child / young person has not achieved continence
- ☐ Child / young person has restarted bedwetting
- ☐ Child / young person has constipation / soiling / encopresis

Details of person making the referral

Name *(print)*	Signature	Referral Date
Job Title	Base	Tel. No

Consent

Has the parent / carer given their consent for this referral? Yes / No *(circle)*

When a referral is made, written permission MUST be obtained from the child's/young person's parent/carer, as:

1. *Referrals may be discussed in a Multiagency meeting including Health, Education, Children's Centres and Social Services.*
2. *The child/young person may be seen by a Therapist either in a Community clinic (with the parent / carer present) but also in a School clinic (without the parent / carer present).*

I confirm that I have parental responsibility for the child/young person being referred, and give permission for my child to be seen by the relevant health professionals.

Name of Parent / Carer (*print)* **Signed**

Relationship to child **Date**

Please return completed form and any relevant reports to:
CDS & Therapies Triage, West Ham Lane Health Centre, 84 West Ham Lane, Stratford, London E15 4PT

Referrals should be emailed securely to newhamcds@nhs.net either using nhs.net email addresses or via other secure domains such as gcsx.gov.uk or egress secure email