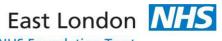
Child Development Service and Therapies Referral Form 2017



NHS Foundation Trust
Community Health Newham

Tel:020 8586 6250/51 Fax:020 82507376 Which service do you require? ☐ Occupational Therapy □ Paediatrician ☐ Physiotherapy (please tick all that apply) ☐ Enuresis clinic ☐ Speech & Language Therapy Section A: Details of child (please fill in all details) Surname Date of birth Gender: Forenames Ethnicity NHS No. Also known as GP RiO No. Address Parent/carer names Home Language Postcode Interpreter required Telephone No. School Health Visitor Year Class School Nurse Child Safeguarding issues? **section B: Reason for referral** (please fill in <u>all</u> details) section C: Medical Information (please fill in all details) Diagnosis (if known) Hearing / vision needs (most recent results) Is child known to other professionals? Physio WC services Dietitian Paediatrician Nurse Other hospital prof $What \ equipment \ does \ the \ child \ use? {\tt e.g. special ist seating/standing frame/hearing aids/wheelchair/walking aids/glasses/special cutlery or cups/standing frame/hearing aids/wheelchair/walking aids/glasses/special cutlery or cups/standing frame/hearing aids/standing frame/hearing fr$ splints / communication book or device / other What other equipment does the child need? Section D: Information about the child's needs Gross motor skills Comments ☐ Child has difficulty co-ordinating both sides of the body... ☐ Child struggles during PE at school ☐ Child's movements appear clumsy ☐ Unable to sit without support. ☐ Difficulties with mobilising / walking ☐ Delayed in development (rolling, crawling, sitting) ii) Fine motor skills Comments ☐ Child has difficulty manipulating objects with hands ☐ Child is unable to grasp and release objects in hands ☐ Child is unable to use both hands together during play ☐ Child has difficulty with handwriting / prewriting

iii) Communication skills		<u>Comments</u>
☐ Child finds it difficult to maintain attention / li ☐ Child has difficulty understanding spoken la ☐ Child finds it difficult to express self e.g. length & complexity of spoken sentene ☐ Child has speech sound difficulties i.e. pronu ☐ Child is aware of difficulties ☐ Child has difficulty forming relationships ☐ Other methods of communication e.g. signing ☐ Other communication difficulties e.g. voice, Please specify:	nguage ces, size and range of vocab inciation g, communication book, pictures	
iv) Sensory needs		<u>Comments</u>
□ Child responds unusually to sensory stimulation e.g. touch / texture on skin / lights / movement / textures in mouth / smells / sounds □ Child seeks out or avoids extra forms of movement e.g., running, spinning, climbing, jumping □ Child engages in self-stimulation/harmful behaviours to either themselves or others.		
v) Eating, drinking and swallowing concerns		Comments
 □ Child has signs of difficulty when eating/drinking e.g. Coughing / gagging / flushed cheeks / watery eyes □ 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? 		
vi) Activities of daily living		<u>Comments</u>
☐ Child requires extra help when eating ☐ Child requires extra help with dressing ☐ Child is not yet toilet trained or requires extra help ☐ Child has difficulty with following a sleep routine ☐ Child has problems with bathing/teeth brushing/grooming		
Section E: Details of person making the referral		
● Name (print)	● Signature	Referral Date
● Job Title	● Base	● Tel. No:
Section F: Consent		
Has the parent/carer given their consent for this referral?		
 When a referral is made written permission MUST be obtained from the child's parent/carer in the box below as; 1. Referrals may be discussed in a multiagency meeting including health, education, children's centres and social services. 2. The child may be seen by a therapist either in a community clinic or in a school clinic (without the parent/carer) 		
I give permission for (child's name) to be seen by the relevant health professional/s and for referrals onto other services as appropriate.		
Name of Parent/Carer (print)	Signed	
Relationship to child	Date	