Child Development Service and Therapies Referral Form 2017

East London NHS
NHS Foundation Trust
Community Health Newham
Tel:020 8586 6250/51 Fax:020 82507376

Which service do you require? (please tick all that apply)
☐ Occupational Therapy
☐ Physiotherapy
☐ Speech & Language Therapy
☐ Paediatrician
☐ Enuresis clinic

Section A: Details of child (please fill in all details)

● Surname :	● Date of birth	Gender: Please select
● Forenames	Ethnicity	NHS No.
Also known as	GP	RiO No.
● Address ● Postcode ● Telephone No.	Parent/carer names ● Home Language ● Interpreter required Please select ...	
● School Year Class	Health Visitor / School Nurse	
Child Safeguarding issues? Please select ...		

Section B: Reason for referral (please fill in all 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?

SLT ☐ OT ☐ Physio ☐ WC services ☐ Dietitian ☐ Paediatrician ☐ Nurse ☐ Other hospital prof ☐

- What equipment does the child use? e.g. specialist seating / standing frame / hearing aids / wheelchair/ walking aids / glasses / special cutlery or cups / splints / communication book or device / other

- What other equipment does the child need?

Section D: Information about the child's needs

i) 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

Please turn over!

iii) Communication skills — Comments

☐ Child finds it difficult to maintain attention / listening skills
☐ Child has difficulty understanding spoken language
☐ Child finds it difficult to express self
e.g. length & complexity of spoken sentences, size and range of vocab
☐ Child has speech sound difficulties i.e. pronunciation
☐ Child is aware of difficulties
☐ Child has difficulty forming relationships
☐ Other methods of communication e.g. signing, communication book, pictures
☐ Other communication difficulties e.g. voice, stammer, hearing difficulties.
Please specify:

iv) Sensory needs — Comments

☐ 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 — Comments

☐ 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? Please select ...

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**

Please return completed form and any relevant reports to:
Intake Team, West Ham Lane Health Centre, 84 West Ham Lane, Stratford, London E15 4PT
Referrals can be e-mailed to newhamcds@nhs.net but they are only secure from other nhs.net addresses or secure domains such as gcsx.gov.uk