

### East Sussex Children’s Integrated Therapy Service

### referral form

Please discuss this referral and obtain consent from parents/carers before proceeding

This referral form is designed to be completed electronically

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| **Background information**  Please complete all sections that are marked with an asterisk. The referral will be rejected if mandatory sections are not completed |

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| **Child’s details** | | | | | | |
| \*Child’s First Name: | | | \*Child’s Surname: | | | \*Gender: Male/  Female |
| \*Date of Birth: | | | NHS Number: | | | \*Age: |
| \*Address:  \*Postcode:  \*Contact Number(s):  Email Address: | | | **\*Please provide names and addresses of all with a legal parental responsibility**  *(refer to the section on parental consent on the final page of this form for a definition of legal parental responsibility)* | | | |
| **Languages** | | | | | | |
| \*Child/ young person’s main language:  \*How long has the child been exposed to English?  \*Is an interpreter required for parental discussion? Yes/ No/ Don’t know  \*Is an interpreter required for child’s assessment? Yes/ No/ Don’t know  \*If yes, what language? (include signing) | | | | | | |
| **Safeguarding** | | | | | | |
| \*Is the child known to Social Services?  Yes/No  \*Is the Child a Child in Need Yes/No  \*Is the Child subject to a Child Protection  Plan? Yes/No  \*Is the child a Looked After Child? Yes/No  \*Local Authority with responsibility: | | If yes:  \*Name of Social Worker:  \*Address for Social Worker:  \*Contact number for Social Worker: | | | | |
| **Referrer’s details** | | | | | | |
| \*Name of Referrer:  \*Job Title: | | \*Address:  \*Tel: | | | | |
| **Other professionals’ details** | | | | | | |
| \*GP:  \*Address:  \*Tel: | \*Health Visitor/School Nurse:  \*Address:  \*Tel: | | | | Other professionals or agencies involved. Please detail reason for involvement | |
| **Have referrals been made to other services?** Please provide dates | | | | | | |
| **Pre-School/ school details** | | | | | | |
| Name & Address of Pre-School/School: School Year:  Name & Job Title of Contact Person: Tel No:  **DOES THE Child have an EHCP** Yes/No/In process of application  **Current educational attainment:**  If Yes please provide EHCP annual review date:   |  |  |  |  | | --- | --- | --- | --- | | Reading: | Writing: | Maths: | Science: | |  |  |  |  | | | | | | | |
| **\*Current additional support**  **Is the child attending any groups to promote development, including preschool, school, out of school or community groups?**  **Evidence of Jump Ahead sessions, Sensory Circuits or completing Language Link programmes may be required prior to accepting referrals. Please refer to referral guidance booklet for further information.** | | | | | | |
| **\*How are you hoping we can help?**  Please write a short description about:  What is the functional impact of this problem on the child/ young person’s daily life?  What have you previously tried and what impact did this have? | | | | | | |
| **Medical History** (include any diagnoses that have been made, illnesses, medication, hospital admissions)  \*Does the child have any allergies? Yes/ No  If yes, please specify:  \*Has the child had one of the following diagnoses:  Down Syndrome Yes / No  Congenital foot abnormalities e.g. Talipes (Club Foot) Yes / No  Preferential head turning (Torticollis) Yes / No  Hip dysplasia (DDH) Yes / No  Shoulder dystocia with apparent neuro muscular signs (Erb’s Palsy) Yes / No  Chest conditions including Cystic Fibrosis Yes / No  If yes, please indicate here. **You do not need to complete the section on Functional Skills.**  \*Has the child/ young person received a diagnosis(es)? Yes/ No  If Yes, please specify:  What current medications are the child/ young person using?  Has the child/ young person experienced any serious illness or frequent illness?  \*Has the child/ young person had any hospital admissions? Yes/ No | | | | | | |
| **\*Hearing Status**  Neonatal hearing screening status:  Date of pass/ referral to Audiology:  Other referrals to Audiology:  Date of Referral:  Results: | | | | **\*Vision/ visual perception**  Wears glasses?  Nystagmus:  Other concerns: | | |
| **\*Under 5s: Developmental Information – please fill in as fully as possible**  **When did the child first**  Roll over:  Sit independently:  Crawl/ bottom-shuffle (please specify):  Pull to stand:  Cruise around the furniture:  Walk independently:  Point/ clap/ wave (please specify):  Respond to a simple instruction e.g. ‘wave bye-bye’ or ‘give to mummy’  Babble:  Use first words:  Put words together to make 2 word sentences: | | | | | | |
| **\*Over 5s Developmental Information – please fill in as fully as possible**  Walk independently:  Develop hand preference:  Use first words:  Toilet training: | | | | | | |

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| **Functional skills**  **Please only fill in the sections below that are relevant to your current concern and reason for referral** |

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| **Play, interaction and attention**  Please complete this if you are concerned about general development and/ or early development of communication | |
| What types of games/ toys/ activities does the child enjoy? |  |
| Does the child like to play with others (adults or children)? |  |
| Can the child sit still and attend during an activity? Of their own choice? Adult-directed? |  |
| Can the child tolerate a change in their routine? |  |
| Does the child avoid certain activities more than their peers?  Please give an example: |  |
| Does the child seek certain activities more than their peers?  Please give an example: |  |

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| **Speech, language and communication**  Please complete this if you have questions about development of communication | | | | | |
|  | Finds difficult | | Can do with support | Can do well | Comments |
| Attention, listening and concentration |  | |  |  |  |
| Understanding spoken instructions |  | |  |  |  |
| Using speech sounds clearly – is it easy to understand the child’s speech production? | Only familiar adults understand child’s speech | | Some can understand child’s speech | Everyone can understand child’s speech | *If you are concerned about speech sounds please complete some examples on the next row* |
| Please give some examples of how the child pronounces words | |  | | | |
| Does the child use single words, phrases or sentences to communicate? Please give an example of how they might ask for something | |  | | | |
| Does the child stammer? If so, please briefly describe the stammer | |  | | | |
| Is there a family history of speech or language difficulties, e.g. late talking, unclear talking, stammering? Please give details | |  | | | |
| Is the child’s speech and language in line with their general development? | |  | | | |

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| **Eating and drinking**  Please complete this if you have questions about the development of eating and drinking | |
| Have there been any recent changes in the child’s ability to eat or drink?  e.g. increased gagging/ coughing; difficulty managing more complex food texture; not coping with usual textures or drinks; concerns about deterioration of skills |  |
| Has there been any recent sign of aspiration or choking?  e.g. coughing/ gurgly voice/ red face; rattly breathing sound when eating or just after eating |  |
| Eating, drinking and swallowing history, please include relevant birth information; weaning; moving to lumpy foods; finger foods etc |  |
| Is there a history of chest infections or respiratory difficulties? |  |
| Is there a diagnosis of reflux or signs of reflux? Please include any medication for reflux |  |
| Is there any vomiting? |  |
| Has the child lost or gained weight significantly in the past 2-4 months? |  |
| Please describe the current eating and drinking regime, including any alternative feeding intake and quantity. Please include a description of mealtimes and food/ drink offered. |  |
| Are there any difficulties drinking? What does the child use to drink from? Do they use a teat or spout? |  |
| Please describe the quantity and types of fluid the child drinks? |  |
| Please describe seating for mealtimes and the length of time taken at mealtimes |  |
| Are there any signs of pain or discomfort at, or just after mealtimes? |  |
| Are there any sensory issues or challenging behaviour around mealtimes? |  |

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| **Physical**  Please complete this if you have questions about physical development | | | | |
| How does your child get about indoors? | |  | | |
| How does your child get about outdoors? | |  | | |
| Do you have any concerns about movement or muscle tone? | |  | | |
| Is there any existing equipment in place, e.g. walker, standing frame? | |  | | |
| *Please tick appropriate box* | Finds difficult | Can do with support | Can do well | Comments |
| Walking |  |  |  |  |
| Running |  |  |  |  |
| Up and down stairs |  |  |  |  |
| Balance including jumping and hopping |  |  |  |  |
| Ball skills including throwing and catching |  |  |  |  |

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| **Independence**  Please complete this if you have questions about general development and/or the development of functional independence | | | | |
| *Please tick appropriate box* | Finds difficult | Can do with support | Can do well | Comments |
| Dressing and undressing, including fastenings |  |  |  |  |
| Cleaning teeth |  |  |  |  |
| Washing and drying face, hands and body |  |  |  |  |
| Using cutlery |  |  |  |  |
| Going to the toilet |  |  |  |  |
| Is there any existing equipment in place, e.g. bath-board, toilet step? | |  | | |

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| **Housing adaptations**  Please complete this if housing adaptations may be required | |
| Please describe the difficulties within the home for the child, family members and carers due to the child’s medical needs |  |
| Transfer skills  Please describe the child’s level of transfer skills i.e. getting in and out of bed; on and off a chair and the toilet and any assistance they need |  |
| Mobility skills  Please describe the child’s level of mobility within and outside the home, including the risk of falling and any assistance they need |  |
| Toileting  Please describe the child’s level of toileting skills and any assistance they need |  |
| Bathing  Please describe the child’s bathing and personal care skills and any assistance they need |  |
| Where are the child’s bedroom, bathroom and toilet facilities located in the property? |  |
| Is there a garden?  i.e. a front and/ or back garden; how do you access this area? |  |
| Are there any equipment items in the home to assist your child?  e.g. wheelchair; bathing aides; seating aides |  |
| Is the child’s home privately owned, privately rented, council property or housing association? |  |

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| **Foundation and classroom skills**  Please complete this if you have questions about general development and/or co-ordination for nursery and school-aged children | | | | |
| *Please tick appropriate box* | Finds difficult | Can do with support | Can do well | Comments |
| Drawing and writing |  |  |  |  |
| Using scissors |  |  |  |  |
| Following instructions |  |  |  |  |
| Organisation |  |  |  |  |
| PE activity |  |  |  |  |

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| **Other supporting information**  We welcome other supporting information. Please identify below any other supporting information you have included with this referral |
| Schedule of Growing Skills  Ages and Stages Questionnaire  Speech, language and communication monitoring tool  Language checkers  Provision plan/ IEP or EYFS learning journey  Other: |

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| **Parental consent to the referral must be gained before the referral can be made.**  **Please attach the parental consent form with this referral otherwise this referral will not accepted.** | | |
| **Signature of Referrer**  ………………………………………………………………………… Date ………………………………………………………….  Please print name:………………………………………………………….. | | |
| **East Sussex Children’s Integrated Therapy Service Consent Form** | | |
| **Child’s Name:** | **Date of Birth:** | **Age:** |
| The person signing this form needs to have Parental Responsibility\* for the young person concerned. Only one  Signature is required. Please would you sign and return this consent form, confirming you agree to the below:   * A Mother automatically has parental responsibility for her child from birth. * In England and Wales, if the parents of a child are married to each other at the time of the birth, or it they have jointly adopted a child, then they share parental responsibility. * For couples who are not married: From 1 December 2003 a Father shares parental responsibility if he jointly registers the birth of the child with the mother (ie he puts his name on the child’s birth certificate). Before 1 December 2003 a Father must have signed a Parental Responsibility Agreement with the Mother or have obtained a Parental Responsibility Order from the Court in order to share parental responsibility for the child.   Parents do not lose parental responsibility if they divorce. Parental responsibility can be changed by order of the Court. | | |
| **I give permission for: (please complete as appropriate)**  Information gathering prior to assessment Yes/No  My child to be seen by a member of East Sussex Children’s Integrated Therapy Service Yes/No   1. Reports to be distributed to    1. Other Health Professionals Yes/No    2. Preschool/school venue Yes/No    3. Other Agencies involved with my child Yes/No   If we have any **safeguarding concerns** we are required to share information with all  Agencies regardless of permission given   1. A Student Speech & Language Therapist, Physiotherapist or Occupational Therapist   to be present during my child’s assessment or therapy sessions Yes/No | | |
| I am aware that information on my child is held electronically in accordance with the Data Protection Act  (please tick the box) | | |
| We are required by the Government to monitor that all health services are equally accessible to all groups within the community. Please choose a code from the list below that best described your child’s ethnic origin.   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | White | A | British |  | Black or Black  British | M | Caribbean |  | | B | Irish |  |  | N | African |  | | C | Any other white background |  |  | P | Any other Black background |  | | Mixed | D | White and Black Caribbean |  | Other Ethnic | R | Chinese |  | | E | White and Black African |  |  | S | Any other ethnic category |  | | F | White and Asian |  | Patient asked | Z | Patient asked but declined |  | | G | Any other mixed background |  |  | | | | | Asian and  British Asian | H | Indian |  | | J | Pakistani |  | | K | Bangladeshi |  | | L | Any other Asian background |  | | | |
| Signature:…………………………………………………………… Printed Name:……………………………………………….  Relationship to Child:……………………………………………… Date:…………………………………………………………. | | |
| We prefer to receive referrals electronically. You can email referrals **to: kentchft.citesrefteam@nhs.net**  For Royal Mail please send this referral to: **Chaucer Clinic, Unit A4, Chaucer Business Park, Dittons Road, Polegate, East Sussex. BN26 6QH** | | |