**Community Paediatric Physiotherapy Referral Form**

*Please complete this form in block capitals/typed*

**(Please note: Incomplete referral will not be processed)**

**We are not commissioned as a musculoskeletal service and all referrals of this nature should be referred via your GP to the musculoskeletal services at Addenbrookes or Hinchingbrooke hospitals.**

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| **Name:** | **Date of Birth:** | **Gender:** Male/ Female |
| **Address:** | **Phone:**  **Home:**  **Mobile:** | |
| **GP:** | **NHS number:**: | |
| **School (**if applicable)  **Does the child have an EHC plan/statement?** (please outline support provided) | | |
| **Consent to receive SMS text for appointment reminder Yes / No** | | |

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| **Reason for referral** (presenting condition): |
| **Diagnosis** (if known): |
| **History of presenting condition** (including parental/school concerns): |
| **Has the child received physiotherapy input in the past: Yes / No**  If yes, detail where, who and advice given: |
| **What interventions (related to this issue)** have been tried in the past or are currently taking place and who is providing them? |
| **Previous physiotherapy strategies and advice adhered to:** |
| **Past medical history:** |
| **Social History** (including home situation, cultural, social): |
| **Any other relevant information** (play and leisure activities; child protection issues, translation requirement etc): |
| **Other professionals involved (tick if applicable and give contact details):**  Speech and Language Therapy / Occupational Therapy / Health Visitor / Paediatrician / Social Work  Educational psychologist / Other  **Are you making a referral to any other service at the same time as this referral?** |
| **Referrer’s name, contact detail and telephone number:**  **Date:** |

**Please return this form with any available reports to:**

*Postal address:* Children’s Therapy Services*,* The Peacock Centre*,* Brookfield’s Hospital Campus

Mill Road, Cambridge CB1 3DF Tel: 01223 218065

*Email address:* [CCS-TR.therapyreferrals@nhs.net](mailto:CCS-TR.therapyreferrals@nhs.net)

**PARENTAL CONSENT**

|  |  |  |
| --- | --- | --- |
| **Consent for Referral** | | Yes / No |
| **Digital Communication** | | |
| Cambridgeshire Community Services (CCS) NHS Trust would like to send text (SMS) messages for appointment reminders and to share useful health information.  **I agree to receive text (SMS) messages** | | Yes / No |
| We may offer appointments using video calling.  **I agree to having video call appointments** | | Yes / No |
| We would like to send your letters or reports by email, which could include personal, sensitive data. If you select yes, we will not send your letters or reports in the post, we will email them to you instead. You will receive a verification email which you must act on as confirmation that we have the right details.  We cannot email you any information without this verification.  **I agree to receive emails which could include personal information:**  Once any information has left our secure NHS email accounts, the security of the information is your responsibility. | | Yes / No |
| **Sharing information** | | |
| Are you happy for us to share your child’s record with other health services who are involved with your child’s care? | | Yes / No |
| Are you happy for us to have access to the records held by other health services involved in your child’s care? | | Yes / No |
| Are you happy for us to share information with education and the local authority i.e School / SEND? | | Yes / No |
| If required, are you happy for us to share information with Social Care? | | Yes / No |
| **SIGN:** |  | |
| **PRINT:** |  | |
| **RELATIONSHIP TO CHILD:** |  | |
| **DATE:** |  | |