**Community Paediatrics School Referral Form for Medical Assessment of a Neurodevelopmental Disorder**

**Please read before completing:**

For primary school age children in mainstream schools Community Paediatrics offers assessments for children with neurodevelopmental concerns. The threshold for assessment is high. Support is needs based and is not determined by a diagnostic label.

We work closely with SEND Services and information from them will feed into the assessment process if there is evidence of the young person having SEND involvement. If they are not already involved, then discussion with them should be considered before a referral is made.

Please refer to ‘Information for Referrers’ available at:

<https://www.cambspborochildrenshealth.nhs.uk/services/cambridgeshire-community-paediatrics/>

Information from parents, young person and school may be considered, however please make clear who is supplying the information. We recognise that the views of parents and professionals may differ and therefore it is helpful to understand whose views are being reflected. We would expect that the majority of the information supplied in this form will come from the school setting with additional information from home. It is important that relevant social and family circumstances are also included. If there is additional Social Care involvement then this should also be included in this form. Information should be concise and relevant.

Children MUST be registered with a Cambridgeshire GP (*With the* ***exception*** *of Peterborough area)*.

**This referral form cannot be accepted without a parent’s/carer’s signature**.

|  |  |
| --- | --- |
| **What is the primary reason for this referral? (Tick ONE)** | |
| Social Communication and Interaction difficulties |  |
| Attention and hyperactivity out of keeping with developmental level |  |
| Medical assessment for a learning difficulty |  |
| Other. Please specify: |  |
| **What (if any) are the secondary reasons for this referral?** | |
| Social Communication and Interaction difficulties |  |
| Attention and hyperactivity out of keeping with developmental level |  |
| Medical assessment for a learning difficulty |  |
| Other. Please specify: |  |

**YOUNG PERSON’S DETAILS:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | | | **Date of Birth:** |  |
| Address: |  | | | | | | |
| Post code: | | | | | | |
| NHS No: |  | | | | | | |
| Contact Details: | | Mobile: |  | | | | |
| Home: |  | | | | |
| Alternate: |  | | | | |
| Email: |  | | | | |
| Please name **everyone** who has parental responsibility for the young person: | | | | |  | | |
| Do both parents live in the family home: | | | | | | | Yes / No |
| If no can information be shared with both parents: | | | | | | | Yes / No |
| If no can the young person’s address be shared with both parents: | | | | | | | Yes / No |
| Please provide the details of parent not living in the family home if information can be shared: | | | | |  | | |
| Would an interpreter be required for an appointment? | | | | | | | Yes / No |
| If yes please advise of language: | | | |  | | | |
| GP Surgery: | | Please note children must be registered with a GP in the Cambridgeshire Integrated Care System (excluding Peterborough) | | | | | |
| School: | | Please note children in their last term of primary school will not be accepted and should be referred to Younited: <https://www.cpft.nhs.uk/how-to-refer> | | | | | |

**Referrer’s Details:**

|  |  |
| --- | --- |
| Name: |  |
| Job Title: |  |
| Tel: |  |
| Email: |  |
| Address: |  |
| Date completed: |  |

**CONCERNS**

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| --- |
| **School Concerns:** (*Please consider the following areas)* |
| Communication Skills |
| Social Interaction and Managing Relationships |
| Attention and Concentration |
| Restricted or Repetitive Motor Mannerisms / Unusual Interests or Routines |
| Behaviour |
| Sensory sensitivities |
| Mental Health and Emotional Wellbeing |
| General Health |

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| **Parent/Carer Concerns:** *(Please consider the following areas)* |
| Communication Skills |
| Social Interaction and Managing Relationships |
| Attention and Concentration |
| Restricted or Repetitive Motor Mannerisms / Unusual Interests or Routines |
| Behaviour |
| Sensory sensitivities |
| Mental Health and Emotional Wellbeing |
| General Health |

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| --- | --- |
| Do family have similar concerns to school: | Yes / No |
| If no please state how these differ: | |
|  | |

**SUPPORT AND STRATEGIES**

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| Please list what support and strategies are currently being implemented at school.  Consider what effect these interventions have had.  If available, attach relevant SEND report with this referral. |
|  |
| Please list support and strategies that have been offered and taken up by the family.  If there is a significant behavioural concerns we would expect that parents would have accessed some support prior to this referral having been made.  If available, please attach relevant evidence of what behaviour support or parenting courses have been accessed.  *Referrals for attention and hyperactivity cannot be accepted without evidence behavioural support has been accessed.* |
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**ACADEMIC ATTAINMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Is this young person’s academic attainment in line with their peers:** | | | Yes / No |
| If no please quantify the gap using school measures, including current level.  **Please provide a key/brief description of school measures used**, including expected levels for the young person’s year group. | | | |
|  | Current | Expected | |
| Maths |  |  | |
| English |  |  | |
| Science |  |  | |
| Reading |  |  | |
| Writing |  |  | |
| **Is this young person’s academic attainment in line with their ability:** | | | Yes / No |
| If no what do you see to be the barriers | | | |
|  | | | |
| **Is this young person on a reduced timetable:** | | | Yes / No |
| If yes please specify: | | | |
|  | | | |
| **Are they spending time outside the classroom on a regular basis:** | | | Yes / No |
| If yes please specify: | | | |
|  | | | |
| **Is school attendance a problem:** | | | Yes / No |
| If yes please specify: | | | |
|  | | | |
| **Has an EHCP been applied for / in place:** | | | Yes / No |
| If yes please give details: | | | |
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| **Please provide the details of your SEND Link Practitioner:** | |
| Name/Role: |  |
| Tel: |  |
| Email: |  |

**RELEVANT INFORMATION**

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| Please give any relevant information regarding the home setting, include parents and other significant family members, relevant social factors which may have some impact on a child’s presentation.  Include details of separation, bereavement, parental mental health, drug or alcohol issues etc. |
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| **Is the young person and/or family involved with, or previously been known to, Social Care?** | | | Yes / No |
| If yes please provide the details of their Social Worker: | | | |
| Name: |  | | |
| Tel: |  | | |
| Email: |  | | |
| **Are they currently on a Child Protection Plan:** | | | Yes / No |
| If yes under which category? | |  | |

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| **Has the young person already had an assessment for a neurodevelopmental condition?** | | | | | Yes / No | |
| NHS | Yes / No | Previous Area | Yes / No | Private | | Yes / No |
| Please provide further details including clinician and practice name: | | | | | | |
|  | | | | | | |

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| **What are parent / carer expectations from this referral?** |
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| **What would the young person like us to know about them?** |
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| **Please add any other relevant information which you feel is important for us to know when considering this young person:** |
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**RISK ASSESSMENT**

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| **Risk** | **Y / N** | **Details:** |
| Risk of self harm |  |  |
| Risk of violence/harm to others |  |  |
| Risk to young person (accidents/absconding) |  |  |
| Risk to young person (Non-accidental/eg DV, risk from others, safeguarding concerns) |  |  |
| Risk of suicide |  |  |

**SUPPORTING DOCUMENTATION**

*Refer to the ‘Guidance for Referrers’ Document for what to include.*

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| **Please include the information required (✓)**  *Please do not send anything outside of the below as this will not be able to be considered* | |
| Early Help Assessment (EHA) |  |
| Education and Health Care Plan (EHCP) – Final |  |
| Education and Health Care Plan (EHCP) – Request Form |  |
| SEND Report (Specialist Teacher / Educational Psychologist) |  |
| Social Communication Descriptors |  |
| Evidence of behaviour intervention *i.e Parenting Course Certificate / Family Worker Involvement record* |  |
| Previous Assessment(s) |  |

**PARENTAL CONSENT**

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| --- | --- | --- | --- | --- | --- | --- |
| **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**  Please confirm your mobile number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 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. You may 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:**  Please confirm your email address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Once any information has left our secure NHS email accounts, the security of the information is your responsibility. | | | | | | Yes / No |
| **What is your preferred method of communication? (Tick one) ✓** | | | | | | |
| Link by SMS |  | | Attachment by Email | |  | |
| Link by Email |  | | Copy by Post | |  | |
| **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 |
| **An onward referral may be made after your appointment please check the below:** | | | | | | |
| Do you consent to your/your child’s shared care record (used by other organisations using the SystmOne electronic patient record system such as your GP) being accessed by YOUnited/ CPFT?    (Simplified: Are you happy for us to be able to access your child’s health record?) | | | | | | Yes / No |
| Do you consent to us (YOUnited/CPFT) adding information relating to your/your child’s care to their SystmOne shared care record which may be viewed by other NHS professionals such as your/their GP?    (Simplified:  Are you happy for us to share your child’s care details with their GP and other NHS professionals on their health record?) | | | | | | Yes / No |
| **CONSENT TO REFERRAL:** | | | | | | |
| **Do you agree to this referral being made:** | | | | Yes / No | | |
| **Does the young person agree to this referral being made:** | | | | Yes / No / N/A | | |
| Please include further information on young person’s response: | | | | | | |
|  | | | | | | |
| ***Please ensure all consent questions are answered above to not cause any delays.*** | | | | | | |
| **PARENT / CARER SIGN:** | |  | | | | |
| **PARENT/ CARER PRINT:** | |  | | | | |
| **RELATIONSHIP TO YOUNG PERSON:** | |  | | | | |
| **DATE:** | |  | | | | |

Thank you for taking the time to complete this referral.

Please email this completed form with any supporting documents to [ccs.tr.communitypaediatricscambs@nhs.net](mailto:ccs.tr.communitypaediatricscambs@nhs.net).