**Community Paediatrics Professional Referral Form**

**Please read before completing:**

If you are referring a child for assessment of a potential neurodevelopmental disorder please complete the relevant form which is available at:

<https://www.cambscommunityservices.nhs.uk/Cambs-Community-Paediatrics/about-us/how-to-refer-to-professionals>

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

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

**CHILD’S DETAILS:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | | | **Date of Birth:** |  |
| Address: |  | | | | | | |
| NHS No: |  | | | | | | |
| Contact Details: | | Mobile: |  | | | | |
| Home: |  | | | | |
| Alternate: |  | | | | |
| Email: |  | | | | |
| Please name **everyone** who has parental responsibility for the child: | | | | |  | | |
| Do both parents live in the family home: | | | | | | | Yes / No |
| If no can information including child’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: | |  | | | | | |

**Referrer’s Details:**

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

|  |
| --- |
| **What is the reason for this referral?** |
|  |

|  |  |
| --- | --- |
| **Have you referred elsewhere and they have recommended a referral to Community Paediatrics?** | Yes / No |
| If yes please provide the details of this service and copy of correspondence: | |
|  | |

|  |  |  |
| --- | --- | --- |
| **Is the child 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 |

**PARENTAL CONSENT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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.*** | | | | | |
| **SIGN:** | |  | | | |
| **PRINT:** | |  | | | |
| **RELATIONSHIP TO CHILD:** | |  | | | |
| **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).