Hertfordshire Community NHS Trust

Children and Young Peoples Therapies Referral Form GUIDANCE

This guidance is intended to help referrers complete this referral form for an individual child. Essential information is highlighted and advice given on what information you may want to include when making a referral.

All referrals must have sections 1 – 6 completed, then additional sections as appropriate

1. DATE OF REFERRAL: xx.xx.xx (ESSENTIAL)		
2. PATIENT DETAILS		
First name: (ESSENTIAL)	Last name: (ESSENTIAL)	Date of birth: xx.xx.xxxx (ESSENTIAL)
Address: (ESSENTIAL)		Postcode: (ESSENTIAL)

NHS No: please include if known as it helps us to process your referral more quickly	Sex: Male / Female (ESSENTIAL)	GP Practice: Please provide surgery name as we check this to ensure children are elligible for our service
Ethnicity:	Language Spoken:	Interpreter required: Y ☐ / N ☐

Disability: Y☐ / N☐ Does patient requires reasonable adjustments to be made: Y ☐ / N ☐

If so, please state what is required:

Parent/Guardian Name: (ESSENTIAL)	Address (if different from above):
Mobile telephone number: At least one telephone number must be provided	
Home telephone number: At least one telephone number must be provided	

3. REFERRER DETAILS	
Referrer Name: (ESSENTIAL) Relationship to Patient: (ESSENTIAL) Contact Telephone number: (ESSENTIAL)	Organisation and address: (ESSENTIAL) This information enables us to contact you with any queries regarding the referral and to inform you of the outcome.

4. CONSENT:

This referral has been discussed with the parent/guardian. They have given consent to this information being shared with the service provider. (Referrals will not be accepted if consent is not indicated) ☐ (ESSENTIAL)

You are advised to read the service's referral guidance and/or discuss the referral via the Advice Line before submitting a referral. Details of these are available at https://www.hct.nhs.uk/our-services/children-young-peoples-therapies-service/

Tick all services you are requesting a referral to:

Occupational Therapy ☐ Physiotherapy ☐ Speech and Language Therapy ☐

(ESSENTIAL) – At least one of the above boxes must be ticked. You may tick more than one box if assessment is required from more than one of the services.

5. ADDITIONAL INFORMATION This section helps us to understand a child's needs better at point of referral and to liaise with appropriate professionals

Safeguarding concerns: Y ☐ / N ☐ Name and Contact number for Social Worker: …… Transfer in whilst having therapy?: Y ☐ / N ☐ Early Support / CAF / EHCP?: Y ☐ / N ☐ Name and contact number of School/College/ Nursery / Pre School:	**Provide Name and Contact number for other Professionals involved** Paediatrician/Consultant: Educational Psychologist: Advisory Teacher: Family Support Key Worker: Independent/Hospital Therapist: Dietician: Respiratory team: Other:

6. RELEVANT MEDICAL HISTORY / BACKGROUND INFORMATION

Other developmental / medical history or medical diagnosis:
Please provide a summary of any relevant information as this helps us to triage the referral

……

What support in preschool / school / college does the child or young person currently receive?
(ESSENTIAL) It is important for us to understand what support is already in place for the child when making decisions about what assessment and support is required from our service following referral. If you have any additional documents such as a CAF, learning profile, IEPs/similar or screening checklists it is useful to attach these to your email when sending the referral through.

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Have they been seen by an Occupational Therapist / Physiotherapist / Speech and Language Therapist before?
Knowing whether they have been seen before allows us to look at previous health records and make decisions about what assessment and support is required from the service.

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7. OCCUPATIONAL THERAPY Complete ONLY if referring to Occupational Therapy

Child or Young Person has difficulty with the following: (ESSENTIAL) – we usually require at least 2 boxes to be ticked

Using cutlery	☐	Washing	☐
Dressing themselves	☐	Toileting	☐
Fine Motor skills e.g. Pencil/scissor skills	☐	Sensory difficulties	☐
Mobility in their environment	☐	Other (please specify) ☐	……

Please describe your concerns and the impact on their everyday life: (ESSENTIAL)

Providing as much detail here as possible will help us to identify the child's needs more quickly. If completing this form electronically this space will expand to allow you to provide sufficient information. Referrals may not be accepted if this is left blank or if it is not clear what impact their difficulties are having.

Is this an urgent referral due to discharge from hospital? ☐ YES ☐ NO Children being discharged from hospital are managed through a different pathway, reflecting their health needs.

7a. Access and Safe Handling Team (Occupational Therapy)

Please give a brief description of the child's access and mobility in their setting:

You are only required to complete this section if making a referral due to concerns about access and mobility. This is sometimes known as 'moving and handling' advice and is likely to be managed by our School Access and Safe Handling team.

8. PHYSIOTHERAPY – only to be completed by a health professional if making a physiotherapy referral

(ESSENTIAL) – at least one box must be ticked

☐ The child or young person has a physical, developmental or medical condition that impacts on their physical development and /or functional everyday activities.

☐ The child or young person has a condition which causes pain.

Note that referrals are normally accepted if the child has flat feet or an in toeing/out toeing gait and where there are no other concerns or neurological involvement.

If the child is over 8 years of age with an orthopaedic or musculoskeletal condition unrelated to child development these referrals should be made to Adult MSK out patient services.

Please give details of any specific functional difficulty e.g. mobility, balance, co-ordination: (ESSENTIAL)

Providing as much detail here as possible will help us to identify the child's needs more quickly. If completing this form electronically this space will expand to allow you to provide sufficient information. Referrals may not be accepted if this is left blank or if it is not clear what impact their difficulties are having

9. SPEECH AND LANGUAGE THERAPY Complete ONLY if referring to Speech and Language Therapy

Child or Young Person has difficulty with: (ESSENTIAL) – at least one box must be ticked

Understanding Language	☐	Hearing	☐	Date tested:
Spoken Language	☐	Voice	☐	(please include ENT report)
Speech sounds	☐	Other	☐	(please specify): e.g. feeding
Social Interaction	☐	Fluency (stammering)	☐	

Please describe your concerns and the impact on their everyday life: (ESSENTIAL)

Providing as much detail here as possible will help us to identify the child's needs more quickly. If completing this form electronically this space will expand to allow you to provide sufficient information. Referrals may not be accepted if this is left blank or if it is not clear what impact their difficulties are having

9a. Additional eating & drinking information – only to be completed by a health professional if referring to the Speech & Language Therapy Dysphagia Team

Is this a referral for a current inpatient Y☐ / N☐ (ESSENTIAL)

Is Parental consent given for therapist to contact other professionals for additional information prior to contact being made with the family? Y☐ / N☐ (ESSENTIAL)

Current Feeding Method: providing as many details in the sections below helps us to process your referral and identify the child's needs more quickly.

Oral feeding only ☐		Oral and Non-oral feeding ☐	Non Oral feeding only (NBM) ☐ NG ☐ PEG ☐ Other (specify) ☐
Details of texture:	Liquid ☐	Thickened Y ☐ / N ☐ (state consistency if known) e.g. Stage 1	
	Food ☐	Puree Y ☐ / N ☐ Mash Y ☐ / N ☐ Finger foods Y ☐ / N ☐ Give examples:	

Please give details of difficulties observed/reported during feeding:
If referring with a consultant letter/report then please attach this to your email. Letters and reports detailing the child's feeding method and concerns can be accepted instead of completing the table(s) above/below.

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Are there current concerns about: Child's intake Y ☐ / N ☐ Safety of child's swallow Y ☐ / N ☐

While feeding does the child ever:-	cough	☐	gag	☐	vomit	☐
	food refuse	☐	wheeze	☐	change colour	☐
	become fatigued	☐			become distressed	☐