



## COMMUNITY CHILDREN'S HEALTH PARTNERSHIP REFERRAL FORM

THIS FORM MUST BE COMPLETED FOR ALL REFERRALS TO BRISTOL COMMUNITY CHILDREN'S SERVICES

<b>NATURE OF REFERRAL</b>		<input type="checkbox"/> URGENT	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> Referral on
<b>CHILD OR YOUNG PERSON BEING REFERRED</b>				
NHS Number:		ICS Number: Hospital Number:		
Surname of Child/Young Person:		Address:		
First Name/s:		Postcode: Home tel no: Mobile no:		
Date of Birth:	Male/Female:			
<b>DETAILS OF PARENT/CARER:</b>				
Parent/Carer's Full name and Relationship to Child:				
Name and address of person with legal responsibility if different from above:				
<b>ETHNIC CATEGORY – Mandatory for Completion:</b>				
<input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other white background		<input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any other mixed background		<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background
<input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other black background		<input type="checkbox"/> Chinese <input type="checkbox"/> Any other categories		<input type="checkbox"/> Not Stated
<b>DETAILS OF SCHOOL/NURSERY/PRE-SCHOOL</b>			<b>DETAILS OF GP</b>	
Name and Address of School, Nursery or Pre-School:			Name of GP and Practice Address:	
			GP informed of Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If NO, please send a copy of the referral form to GP</b>	
<b>CHILD PROTECTION DETAILS</b>				
Child Protection Plan ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Has the child been on a Child Protection Plan in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Is the Child 'Looked After' (e.g. Fostered) by the Local Authority? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>CONSENT</b>				
Has The person with Legal Responsibility consented to this referral?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<b>CHILD/YOUNG PERSON TO BE REFERRED TO</b> (please tick only one box where possible)				
<input type="checkbox"/> Child and Adolescent Mental Health Service (CAMHS) <i>NB. CAMHS only accepts referrals from Health Professionals and CYPS Team Managers</i>				
<input type="checkbox"/> Community Paediatrician		<input type="checkbox"/> School Health Nursing Service (via internal Referral Pathway)		
<input type="checkbox"/> Speech and Language Therapist		<input type="checkbox"/> Occupational Therapy (via internal Referral Pathway)		
<input type="checkbox"/> Physiotherapist		<input type="checkbox"/> Specialist Children's Learning Disability Service		
<input type="checkbox"/> Clinical Psychology – Disability Service				

