Community Children's Health Partnership

COMMUNITY CHILDREN'S HEALTH PARTNERSHIP REFERRAL FORM

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

NATURE OF REFERRAL	☐**URGENT**	☐**ROUTINE**	☐**Referral on**

CHILD OR YOUNG PERSON BEING REFERRED		
NHS Number:		
Surname of Child/Young Person:		**Address:**
First Name/s:		
Date of Birth:	**Male/Female:**	**Postcode:** **Home tel no:** **Mobile no:**

DETAILS OF PARENT/CARER:
Parent/Carer's Full name and Relationship to Child:
Name and address of person with legal responsibility if different from above:

ETHNIC CATEGORY – Mandatory for Completion:		
☐**British** ☐**Irish** ☐**Any other white background**	☐**White & Black Caribbean** ☐**White and Black African** ☐**White & Asian** ☐**Any other mixed background**	☐**Indian** ☐**Pakistani** ☐**Bangladeshi** ☐**Any other Asian background**
☐**Caribbean** ☐**African** ☐**Any other black background**	☐**Chinese** ☐**Any other categories**	☐**Not Stated**

DETAILS OF SCHOOL/NURSERY/PRE-SCHOOL	**DETAILS OF GP**
Name and Address of School, Nursery or Pre-School:	**Name of GP and Practice Address:**
	GP informed of Referral? ☐ **Yes** ☐ **No** **If NO, please send a copy of the referral form to GP**

CHILD PROTECTION DETAILS	
Child Protection Plan ? ☐ **Yes** ☐ **No** ☐ **Unknown** **Has the child been on a Child Protection Plan in the past?** ☐**Yes** ☐ **No** ☐ **Unknown**	**Is the Child 'Looked After' (e.g. Fostered) by the Local Authority?** ☐ **Yes** ☐ **No** ☐ **Unknown**

CONSENT
Has The person with Legal Responsibility consented to this referral? ☐**Yes** ☐ **No** ☐ **Unknown**

CHILD/YOUNG PERSON TO BE REFERRED TO (please tick only one box where possible)	
☐**Child and Adolescent Mental Health Service (CAMHS)** ***NB. CAMHS only accepts referrals from Health Professionals and CYPS Team Managers***	
☐ **Community Paediatrician**	☐ **School Health Nursing Service (via internal Referral Pathway)**
☐ **Speech and Language Therapist**	☐ **Occupational Therapy (via internal Referral Pathway)**
☐ **Physiotherapist**	☐ **Specialist Children's Learning Disability Service**

Name of Child / Young Person:	DOB:

Special Requirements: e.g. Do we need a translator for this family, if so please advise which language? Wheelchair Access Required , etc. Please give details below.

ALLERGIES – Please advise if the child/young person has any allergies and what these are.

DETAILS: Please include details regarding onset, duration, severity and effects on family. Relevant history: E.g. Medical, developmental issues and family structure. Please indicate what assessment intervention has already taken place, and how successful this has been. Give contact numbers of those involved where known. Insufficient information may lead to the referral being returned, resulting in delayed treatment of the child.

IS THE CHILD CURRENTLY BEING SEEN BY?			
☐Social Services	☐ Health Services		
☐Educational Services	☐ Vision	☐ Hearing	☐ Other (please specify)

PERSON REFERRING		
Referred by:	Base:	Tel no:
Job Title:	Date of referral:	

Information Sharing:

It is important to ensure that the parent/carer is aware that the information detailed in referrals made to Community Paediatric Services may be shared with other health professionals and external agencies closely associated with health professionals such as education and social services.

FOR OFFICE USE ONLY	Form sent to:	SPE Number:	Locality:
Referral type: ☐Original Referral ☐Referral on ☐Transfer In	Date Received:	Date Entered:	Date Sent:
Existing Professionals Involved with Child: Community Paediatrician ☐ Specialist Health Nursing Service ☐ CAMHS ☐ Specialist Children's Learning Disability Service ☐ OT ☐ Physio ☐ SLT ☐		Please Send Completed Form To: Community Children's Health Partnership, Single Point of Entry, Unit 9 Eastgate Office Centre, Eastgate Road, Eastville, Bristol, BS5 6XX Tel: 0117 340 8201 Fax: 0300 124 5248 Email: sirch.singlepointofentry@nhs.net	

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