**Referral form for ELHT Community & Neurodisability Paediatrics Service**   
**(For professional use in partnership with Parent & Child / Young Person)**

* This form is for use by Health and Education Professionals working alongside ELHT in Blackburn with Darwen and East Lancashire.
* Please complete this form electronically and return to:

[CNPreferrals@elht.nhs.uk](mailto:CNPreferrals@elht.nhs.uk)

* Please respond to all sections - incomplete referral forms will be returned to the referrer to request further information.
* It is advised that the referrer should have an established relationship with the child or young person, and able to offer a professional opinion based on one or more assessments with the child or young person. If this is not the case, it is recommended that the form be directed to the child/ young person’s school to complete. School referrals will very likely provide high quality referral information and prevent avoidable delays in the triage process.

**REFERRER DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Referrer** | Click or tap here to enter text. | **Designation of Referrer** | Click or tap here to enter text. |
| **Address of Referrer** | Click or tap here to enter text. | **Referrer email** | Click or tap to enter a date. |
| **Date of Referral** | Click or tap to enter a date. |  |  |

**CHILD/ YOUNG PERSON DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Forename** | Click or tap here to enter text. | **Surname** | Click or tap here to enter text. |
| **Gender** | Click or tap here to enter text. | **DOB** | Click or tap here to enter text. |
| **Age** | Click or tap here to enter text. | **Address** | Click or tap here to enter text. |
| **Postcode** | Click or tap here to enter text. | **Telephone (home)** | Click or tap here to enter text. |
| **Telephone (mobile)** | Click or tap here to enter text. | **NHS Number** | Click or tap here to enter text. |
| **Ethnicity** | Click or tap here to enter text. | **Language Spoken** | Choose an item. |
| **Language Spoken if Not English** | Click or tap here to enter text. | **Interpreter Required?** | Choose an item. |
| **GP Name/Practice** | Click or tap here to enter text. | | |

**Reason for Referral:**

Referral criteria can be found at the link below:

[Community and Neurodisability Paediatrics :: East Lancashire Hospitals NHS Trust](https://elht.nhs.uk/services/paediatrics/community-and-neurodisability-paediatrics)

***Completion guidance****:*  *Summarise the main reasons for the referral. State if the referral is at the request of the parents.* *Please attach any of the supporting documents requested to your referral email.*

**Include further detail of the reason for referral in relevant text boxes below:**

**Developmental Delay in pre-school children:**

**Select :** No

***Completion guidance:*** *Current developmental profile – gross motors/fine motor/speech and language skills, self-help skills (such as toileting/feeding). Any relevant history affecting development (such as hospitalisation / surgical procedures)*

**Foetal Toxin Exposure (alcohol / toxin or teratogenic medication or infection exposure in pregnancy):**

**Select :** No

***Completion guidance:*** *Any known, or suspected, exposure during pregnancy to: alcohol, substances (e.g. cannabis/cocaine); infection or teratogenic drugs (e.g. sodium valproate).*

**Dysmorphic features / genetic conditions (e.g. Downs Syndrome):**

**Select :** No

***Completion guidance:*** *Dysmorphic feature description. Genetic condition known / concerns about family history of genetic conditionf*

**Autism Concerns:**

**Select :** No

***Completion guidance:*** *Social skills – consider conversational skills, interactions with adults and interactions with peers. Eye contact, use of facial expression and gesture. Restrictive or repetitive speech or behaviour patterns. Rigidity – inflexibility, fixed thinking, difficulty with new places and unfamiliar people.Any passions or obsessions. Sensory processing difficulties. Impact on day to day life and learning progress.*

**ADHD concerns:**

**Select :** No

***Completion guidance:*** *Attention and listening. Activity levels issues and impact of difficulties on day-to-day life and learning progress.*

Please attach supporting information from school, if relevant – either written report or scored questionnaire e.g. SNAP 4,

**Dyspraxia / Developmental Co-ordination Disorder Diagnosis (referrals only accepted from Occupational Therapists):**

Referral to CNP is only required if there are concerns regarding underlying neurological or muscular condition. Attach OT assessment report including Standardised assessment of Motor Skills e.g. Movement ABC / Visual motor Integration / Visual Processing Assessment

***Completion guidance:*** *Description of motor coordination difficulties that are significantly below other areas of development, for example, poor balance, clumsiness or difficulties with skills such as catching, jumping, bike riding, handwriting and using cutlery.  How motor difficulties, without accommodations, significantly and persistently interfere with a person’s ability to undertake age-appropriate activities of daily living/academic achievement. Have symptoms been present from the early developmental period?*

**Medical investigation of medical cause of moderate to severe learning /intellectual disabilities in Children / Young People:**

**Select :** No

***Completion guidance:*** *Describe current learning attainment level in age equivalent terms.*

Attach any cognitive profile /learning assessment reports evidencing moderate to severe learning/intellectual disabilities (e.g. School Assessment Form, CAT Scores/ Specialist teacher/ Educational Psychologist).

**Does the child have cerebral palsy, or are you concerned about the possibility of cerebral palsy?**

**Select :** No

***Completion guidance:*** *Gait – walking pattern/muscle tone or spasticity/ataxia/feeding swallowing difficulties/skeletal issue such as spine curvature/scoliosis or hip dysplasia.*

**Medical Management of complex neurological or genetic conditions (in association with specialist services):**

**Select :** No

***Completion guidance:*** *Known condition or concern about specific condition (e.g. Down’s Syndrome/ Neurofibromatosis/Genetic Syndrome/Muscle Disorders)*

**Additional Parental Concerns (not detailed by referrer):**

Parent 1 page profile may be attached.

**Essential Medical/Family/Social History (ALL REFERRERS MUST COMPLETE THIS SECTION):**

|  |  |
| --- | --- |
| **Any known medical diagnosis** | Click or tap here to enter text. |
| **Any prescribed Medication** | Click or tap here to enter text. |
| **Previous referrals to Community & Neurodisability Paediatrics** | Choose an item.  Click or tap here to enter text. |
| **Birth history/prematurity** | Choose an item.  Click or tap here to enter text. |
| **Have they ever been a Child in Care (home placement or short or long term foster care) or lived away from their family?** | Choose an item.  Click or tap here to enter text. |
| **Under Special Guardianship Order: Please give history / details** | Click or tap here to enter text. |
| **Adopted Child / Young Person: Please give history / details** | Click or tap here to enter text. |
| **Any specific life events, or family circumstances which have or may be impacting upon this child’s or young person’s behaviour? E.g., family upheaval, traumatic experiences, significant health, or behaviour issues in any family member** | Click or tap here to enter text. |
| **Any known adverse childhood experiences (History of parental or household mental health difficulties / Imprisonment / Domestic Violence / Bereavement)** | Click or tap here to enter text. |
| **Any other observations or concerns e.g. Anxiety / low mood / emotional dysregulation /oppositional defiant behaviours** | Click or tap here to enter text. |
| **Previous Early Help Assessment (EHA)** | Click or tap here to enter text. |
| **Previous Early Help Services Involvement – give details:** | Click or tap here to enter text. |

**First Steps Undertaken Prior to Referral (ALL REFERRERS MUST COMPLETE THIS SECTION):**

|  |  |
| --- | --- |
| **Support currently in place** | Click or tap here to enter text. |
| **Is there an EHA open?** | Choose an item. |
| **Previous support** | Click or tap here to enter text. |
| **Assessments undertaken: Please attach assessment reports** | Click or tap here to enter text. |
| **Please attach a copy of the IEP/PEP/EHA** | Click or tap here to enter text. |

**Professionals currently involved / referred and awaiting assessment:**

Early Help

Child Family and Wellbeing

Child Action North West

Speech and Language Therapy

Occupational Therapy

Physiotherapy

Orthotics

Dietician

Audiology

Ophthalmology /Orthoptist

Child and Adolescent Mental Health Services (ELCAS)

Clinical Psychology

General Paediatrician

Tertiary Specialist Service

Other

|  |  |
| --- | --- |
| **Please add any relevant details** | Click or tap here to enter text. |

**Education:**

|  |  |
| --- | --- |
| **Name of Nursery or School** | Click or tap here to enter text. |
| Current School Academic Year | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **School Assessment Form Attached? (can be found at:** [**Community and Neurodisability Paediatrics :: East Lancashire Hospitals NHS Trust**](https://elht.nhs.uk/services/paediatrics/community-and-neurodisability-paediatrics)**)** | Choose an item. |
| All referrals from nursery or school should attach the completed school assessment form | |
| **Please indicate current learning attainment level in age equivalent terms** | Click or tap here to enter text. |
| **Please clarify any SEND support in place or in process of application** | Click or tap here to enter text. |
| **Please list and attach any completed SEND assessments even if historical (eg Specialist teacher or Education Psychology reports) If not already attached in reason for referral section** | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **School refusal / school absence concerns / school exclusions / managed moves** | Click or tap here to enter text. |

**Safeguarding:**

|  |  |
| --- | --- |
| **Please indicate any known safeguarding concerns** | Click or tap here to enter text. |
| **Any history of Children’s Social Care involvement** | Click or tap here to enter text. |
| **Child in Need Plan?** (If yes indicate lead Local Authority) | Click or tap here to enter text. |
| Local Authority if Applicable | Click or tap here to enter text. |
| **Child Protection Plan**  (If yes indicate lead Local Authority) | Click or tap here to enter text. |
| Local Authority if Applicable | Click or tap here to enter text. |
| **Care Order in Place**  (If yes indicate lead Local Authority) | Click or tap here to enter text. |
| Local Authority if Applicable | Click or tap here to enter text. |

**Parent/main carer details:**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Phone number | Click or tap here to enter text. |
| Email address | Click or tap here to enter text. |
| Parental responsibility | Click or tap here to enter text. |
| If no, please enter the details of the person with parental responsibility and confirm they consent to referral (e.g., local authority, foster carer, social worker etc.): | Leave Blank |
| Name | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Phone Number | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Details of any other adult with parental responsibility: |  |
| Name | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Phone Number | Click or tap here to enter text. |
| Are they aware of this referral? | Click or tap here to enter text. |

**Consent for multidisciplinary assessment:**

I confirm I have discussed as below with parent / carer for the child, and they have confirmed their consent for a referral to be made to the Community & Neurodisability Paediatrics Service Assessment Pathway

Relevant information about the above-named child or young person to be requested by and shared with relevant organisations and professionals supporting the delivery of the community and neurodisability paediatric assessment.

Professionals and assessments required for the assessment are individually considered at triage but may include any of the following services or professionals: Neurodevelopmental Practitioner, Speech and Language Therapist, Clinical Psychologist, Child and Adolescent Psychiatrist, Paediatrician, Child Development Centre Assessment.

Information may also be requested from Nursery or School or other agencies or health service, for example General Practitioner, Audiology, Ophthalmology, Specialist Paediatric Services, Children’s Social Care.

Sharing of Family history - Parental health issues, Extended family history ASD / ADHD within the referral form

**Confirmation**

It is essential that consent for multi-disciplinary assessment, as detailed below, be discussed with parent/ carer if the child/ young person is under 16 years of age.

This can be done verbally by telephone or in person.

|  |  |
| --- | --- |
| Name of professional discussing Consent | Click or tap here to enter text. |
| Name of the parent/guardian giving consent | Click or tap here to enter text. |
| Has this been discussed with the child/YP | Click or tap here to enter text. |
| Do they also agree to the referral? | Click or tap here to enter text. |