Community Child Health Referral Form.

Please complete this form for all referrals to community child health. Complete pages 1, 2 & 3 identifying the reason(s) for referral by ticking the box(es) of the appropriate referral criteria. Then complete the additional information page and the appropriate corresponding section(s).

Please note that referrals made for reasons other than those included in the criteria identified below will not be accepted by the department.

Also please consider that if a child is being referred into this service they should ideally have a Common Assessment Framework or Early Help Assessment in place or be in the process of having one completed.

Health visitors - please enclose any up to date ASQ assessments.
Doctors, allied health professionals and schools please attach an up to date summary or report.

Child's Details:
Name:

Address:

Date Of Birth:

Parent/carer:

Contact number:

School/setting:

CAF/EHA number:

CAF/EHA being completed: CAF/EHA declined:

Referrer's Details:

Name:

Profession: General Practitioner

Address:

Contact number:

CHANGING LIVES

Reason For Referral:

- ☐ Developmental delay in 2 or more domains (global developmental delay). Complete section 1.

- ☐ Child below the age of 5 years where there is concern around social communication or interaction or suspected autism spectrum disorder. Complete section 2.

- ☐ Child 5 years and below with significant unexplained challenging behaviour or behavioural difficulties, once parents have agreed to and a place has been attained on a parenting course. Complete section 3.

- ☐ Child with isolated speech and language delay from speech and language therapists only, following an assessment and hearing test. Complete section 4.

- ☐ Child with isolated fine or gross motor delay (if medical cause is suspected) once they have been referred to the appropriate therapy service ie occupational or physiotherapy. Complete section 5.

- ☐ Child with suspected or diagnosed genetic abnormalities or syndromes. Complete section 6.

- ☐ Child or young person with daytime, secondary or refractory primary nocturnal enuresis. Referrals for refractory primary nocturnal enuresis will be accepted from the school nursing team only. Complete section 7.

- ☐ Child with epilepsy. Complete reason for referral section on page 3 if required.

- ☐ Child over the age of 12 months from hospital paediatricians for co-ordination of care and further management. Complete Section 8. Children can be discussed under the age of 12 months of age on a case by case basis and a CDC clinic handover arranged.

Once completed please return your referral form to:
Community Child Health referral panel, Community Child Health department, New Street Health Centre, Upper New Street, Barnsley, S70 1LP.

Reason For Referral:

Please outline your reasons for referral in more detail if this is not included in your attached reports (use additional sheets if required):

Additional documents enclosed with this referral form:

Section 1.

Developmental delay in 2 or more domains: (global developmental delay) will be accepted once the child has been referred to appropriate therapy services.

Identify delay below by ticking the appropriate number and complete the relevant sections.

☐ 1. Speech & language delay

Date referred to speech & language therapy:

☐ 2. Gross motor

Date referred to physiotherapy:

☐ 3. Fine motor

Date referred to occupational therapy:

☐ 4. Sensory

Date referred to occupational therapy for sensory profile assessment (if child is functionally impaired):

☐ 5. Hearing

Date referred to audiology:

☐ 6. Social Interaction - if in a setting, nursey or school

Date referred to communication and interaction team:

☐ 7. Visual

Date referred to ophthalmology:

☐ 8. If child is under 5 years of age and is not in a setting or nursery

Date referred to portage:

Other services/professionals involved:

Section 2.

Child below the age of 5 years where there is concern around social communication or interaction or suspected autism spectrum disorder.

Identify criteria below by ticking the appropriate number and complete the relevant sections.

☐ 1. Concerns around social communication - If in setting, nursery or school:

Date referred to communication and interaction team:

☐ 2. Concerns around sensory issues

Date referred to occupational therapy for sensory profile assessment (if child is functionally impaired)

☐ 3. Concerns around speech delay/regression

Date referred to speech and language therapy:

☐ 4. Concerns around obsessions

☐ 5. Concerns around rigid routinised behaviours.

☐ 6. Concerns about child's behaviour.

Other services/professionals involved:

Section 3.

Child below the age of 5 years with significant unexplained challenging behaviour or behavioural difficulties, **once parents have agreed to and a place has been attained on a parenting course**.

Identify criteria below by ticking the appropriate number and complete the relevant sections.

☐ 1. Concerns re aggressive behaviour

☐ 2. Concerns re challenging behaviour

☐ 3. Concerns re other behavioural difficulties

Date parenting course attended:

OR

Date a place has been attained on parenting course:

Other services/professionals involved:

Section 4.

Child with isolated speech and language delay - from speech and language therapists only, following an assessment and hearing test.

Identify criteria below by circling the appropriate number and complete the relevant sections.

Referred to speech and language therapy by:

Date referred to speech and language therapy:

Date referred to audiology:

Other services/professionals involved:

Section 5.

Child with isolated fine or gross motor delay (where medical cause is suspected). Identify criteria below by ticking the appropriate number and complete the relevant sections.

☐ 1. Gross motor delay

Date referred to physiotherapy:

☐ 2. Fine motor delay

Date referred to occupational therapy:

Other services/professionals involved:

Section 6.

Child with suspected or diagnosed genetic abnormalities or syndromes.

Identify criteria below by ticking the appropriate number and complete the relevant sections.

☐ 1. Diagnosis of genetic abnormality/syndrome.

Diagnosis:

Diagnosed by (if known):

Date (if known):

☐ 2. Suspected genetic abnormality/syndrome

Reason for concern:

Other services/professionals involved:

Section 7.

Child or young person with daytime, secondary or refractory (resistant to treatment) primary nocturnal enuresis. Referrals for refractory primary nocturnal enuresis will be accepted from the school nursing team only.

Identify criteria below by ticking the appropriate number and complete the relevant sections.

☐ 1. Daytime enuresis.

☐ 2. Secondary enuresis

☐ 2. a) daytime ☐ 2. b) nocturnal

☐ 3. Refractory primary nocturnal enuresis (from school nurses only)

Other services/professionals involved:

Section 8.

Child over the age of 12 months (or younger if discussed with a community paediatrician) from hospital paediatricians for co-ordination of care and further management.

1. Date discussed with community child health:
2. Date of CDC clinic:

Other services/professionals involved: