 

**Buckinghamshire Children and Young People’s Therapies 0-19 Referral Form**

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| Which service/s are  you referring to: | Occupational Therapy |  |
| Physiotherapy |  |
| Speech and Language Therapy |  |

**Please note that fields marked with** \* **are mandatory – forms will be returned if these fields are not completed.**

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| **Personal Information** | |
| \*First Name | \*Family Name |
| \*Date of Birth | \*NHS Number |
| \*Male Female | \*Home 🕿 |
| \*Home Address | |
| \*Parent/Guardian Name | |
| \*Home e-mail | \*Mobile |
| \*Language Spoken at Home | \*Interpreter Required: Yes No |

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| **School/Setting Information** | |
| \*School/Setting | |
| \*Attending: Fulltime Part Time | \*SEN Support Plan: Yes Unknown |
| \*Educational Health Care Plan (EHCP): No Yes Requested | |
| Speech/Language Link ID (required for KS1 children): | |

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| **Referrer’s Information** | | | | |
| \* Referrer’s Name (print) | | \*Relationship to child | | |
| \*Referrer’s 🕿 | | \*Date of Referral | | |
| \*Referrers Address | | | | |
| \*Referral agreed with parents/carers: Yes No | | | \*Date agreed with parents/carers | |
| \*Parents/Young person’s main concern: | | | | |
| **Other Professionals** | | | | |
| \*GP Surgery | | \*GP 🕿 | | |
| **Professional** | **Name - if known** | **🕿** | | **Date of last contact** |
| Educational Psychologist |  |  | |  |
| Paediatrician |  |  | |  |
| Consultant/s |  |  | |  |
| Social Worker |  |  | |  |
| Private Therapist/s |  |  | |  |
| CAMHS |  |  | |  |
| Specialist Teaching Service (STS) |  |  | |  |
| Other (please specify) |  |  | |  |

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| **Health Information** |
| \*Was your child born before 36 weeks? Yes No Don’t know  How many weeks? …. /40 weeks Birth Weight: |
| (\*For children under 5 years old) Did your child achieve early developmental milestones appropriately? Yes No – If no please give ages achieved for  Rolling Sitting Crawling Standing Walking |
| Has your child had:  Fits / Seizures / Epilepsy Visual Difficulties Hearing Difficulties Swallowing Difficulties Frequent Colds/Ear Infections Head Injury, Encephalitis, Meningitis, Stroke/CVA Date: \_\_\_\_\_\_\_\_\_ Other  Please give relevant details  : |
| \*Does your child have a confirmed or suspected diagnosis? Yes No If yes please give detail: |
| \*Has your child had any investigations/scans/X-Rays? Yes No Unsure  If yes please give detail: |
| \* Is there a family history of similar difficulties? Yes No Not known  If yes please give details |

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| **Equipment / Orthotics** |
| To support them in their daily life does your child use:  Standing Frame Yes No Mobility Aid Yes No Orthotics Yes No  Specialist Seating Yes No Other Specialist Equipment Yes No  If yes please give detail: |
| Does this equipment/orthotics need review or adjustment Yes No |

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| **Additional Referral Information** |
| Has your child had and previous contact with therapy services::  Speech and Language Therapy Occupational Therapy Physiotherapy  Date/s: |
| Have you and/or your child attended/participated/used any of the following:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | CYP Website (see details below) |  | Other websites |  | Parent Talk |  | | School Talk |  | Rainbow Road |  | Talkboost |  | | Little Talkers |  | Handwriting Club |  | Podiatry |  | | Orthotics |  | MSK Physiotherapy |  | Alternative therapy |  | | OT Resource pack |  | Other: | | | | |
| \*Please explain what supporting strategies have been used and whether they have been successful |
| \*Please indicate the specific difficulty/ies **and** the impact this is having on your child in their day to day life. |

**Please look at our website for advice, resources and activities to support your child with their Speech and Language Therapy, Occupational Therapy and Physiotherapy needs.** [**http://www.buckshealthcare.nhs.uk/Children-and-young-people/**](http://www.buckshealthcare.nhs.uk/Children-and-young-people/)

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| AREAS OF CONCERN |
| Please tick one box to show your level of concern:   1. no concern, 2 – a little concerned, 3 – concerned, 4 – very concerned   If you mark level 3 or 4 you must provide further details. |

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| COMMUNICATION | Level of concern\*  1 2 3 4 | Give details of how this impacts daily life |
| Attention |  |  |
| Sitting and Listening |  |  |
| Understanding of instructions/questions |  |  |
| Not saying enough words |  |  |
| Difficulty with sentences |  |  |
| Play skills |  |  |
| Pronunciation |  |  |
| Stammering/Voice |  |  |
| Selective Mutism  (reluctant speaker) |  |  |

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| PLAY/ LEISURE/SOCIAL SKILLS | Level of concern\*  1 2 3 4 | Give details of how this impacts daily life |
| Making and maintaining friendships |  |  |
| Interaction with adults |  |  |
| Awareness of danger |  |  |
| Movement  (eg Running, Jumping, Walking, Balance) |  |  |
| Taking part/joining in with clubs and family/leisure activities |  |  |
| Playing ball games |  |  |
| Handwriting/Recording work |  |  |
| Using Scissors |  |  |
| Following routines |  |  |

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| SELF CARE | Level of concern\*  1 2 3 4 | Give details of how this impacts daily life |
| Drinking Difficulties  Swallowing Difficulties |  | *A GP/ Consultant referral will be required. Please ensure a medical referral is attached detailing the medical history and feeding concerns.* |
| Dribbling |  |  |
| Toileting |  |  |
| Bathing |  |  |
| Dressing |  |  |
| Brushing Teeth/Hair |  |  |
| Cutlery Skills |  |  |

**Any other concerns:**

Please contact 01296 566045 if you have any queries.

Return fully completed form to: [Buc-tr.cyptherapyreferrals@nhs.net](mailto:Buc-tr.cyptherapyreferrals@nhs.net) or post to CYP Therapies, Haleacre, Amersham Hospital, Whielden Street, Amersham, Bucks HP7 0JD