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| **Graphical user interface, application  Description automatically generatedOver 5-Year-Old**  **Community Pediatric Referral Form** | | | | | |
| All sections should be completed with as much detail as possibleReferrals accepted only from education settings or healthcare professionals. Please be aware that if supporting evidence is not included, the referral will be returned. | | | | | |
| If you do not have the relevant information, please discuss with the Setting SENDCO and parent/carer(s).  This form will only be accepted if completed electronically and emailed to [**bht.communitypaediatricsadmin@nhs.net**](mailto:bht.communitypaediatricsadmin@nhs.net)  In this version of the form, the sections will expand to accommodate the text you enter  **Please note that referrals acceptance must be met:**   * Children must be under a GP within the Buckinghamshire CCG boundaries * Under the age of 19 years, except:   + Children who have recently moved into Buckinghamshire County/or Country   + Attending a special school   + Due to the potential need for Occupational Therapy of Speech and Language support we can only accept referrals for children who are registered with a Buckinghamshire GP   **To ensure the referral can be processed please include the following document: (**Please tick that evidence is included)   * Report from education setting   **The following would also support your referral (**Please tick which evidence is included)  **Supporting Information:** (Please tick which professional are involved and corresponding evidence is included)  Learning Level/Academic Progress:  Report from Educational Psychologist  Individual learning/SEN plan:  SENISS/SENSS:  SALT:  Behaviour Support Services:  CAMHS:  Social Care:  Special School Outreach:  Standardised Spelling Level ………….  Standardised Reading Level …………  Standardised Maths Level …………  Other (e.g. EHC plan):  Family and social background: (Including employment, relevant health issues, social care, housing etc.)  Are there any concerns regarding the child’s emotional wellbeing due to external life events, family or social difficulties?  Hearing Check: Date: Click or tap to enter a date.  Vision Check: Date: Click or tap to enter a date.  **Please state any other professionals that have been involved in supporting this child:**  **Please note that if supporting evidence is not included with this referral, it will be returned.** | | | | | |
| Full Name and Details of the child or young person being referred | | | | | |
| Name: | | | | | |
| Address: | | | | | |
| Date of Birth: | | NHS Number: | | | |
| Gender: | | | | | |
| Parent/Carer Name(s) 1:  Parent/Carer Name(s) 2: | | | | | |
| Other Members of the Household (Age and relationship to child): | | | | | |
| Primary contact number: | | Secondary Contact Number: | | | |
| Parent/Carer email address: | | | | |  |
| Language at Home: | | Special Requirements (Interpreter and if so, specify language): | | | |
| Family and social background: (Including employment, relevant health issues, social care, housing etc.) | |  | | | |
| Name of education setting: | | | | | |
| **Reason(s) for Referral** (What is the clinical question? What is the background to this? What are your findings on observation/examination?)**:**  **Reasons for Referral** (What is the family’s concern? Mandatory field)  Known Medical Conditions/Existing diagnoses/ medication: (include outcomes/formulation of existing assessments if known, e.g. cognitive, mental health, social care assessments, etc.)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Consent: Please Note: Consent should be from a parent/carer with parental responsibility for the child.**  (Tick as appropriate) For this referral:  Please confirm that relevant information can be shared with the appropriate professionals: | | | | | |
| Any other information or comments: | | | | | |
| Referrer Details: | | | | | |
| Name: | | | | | |
| Designation: | Address: | | | Contact Number: | |
| Email address: | | |  |  | |
| Referrer Name: | | | | Date: Click or tap to enter a date. | |