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| **Under 5-Year-Old**  **Pre-School Community Paediatric Referral Form** | | | | | |
| Please refer to community paediatrics referral criteria documentAll 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 processed if completed electronically with the mandatory documents attached, 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  **To ensure the referral can be processed please include the following documents of which the below are linked to the questionnaires (**Please tick that you have attached the evidence)   * [Health visitor report](file:///\\bhtfile01\chi$\Communications%20&%20Media\NEW%20STRUCTURE\COMMS%20VEHICLES\WEBSITE\0000_NEW%20WEBSITE%20for%202021\Microsites\230808_CYP%20Community%20paediatric%20referral%20form\HV%20report.doc)/ASQ completed * [Report from education setting](file:///\\bhtfile01\chi$\Communications%20&%20Media\NEW%20STRUCTURE\COMMS%20VEHICLES\WEBSITE\0000_NEW%20WEBSITE%20for%202021\Microsites\230808_CYP%20Community%20paediatric%20referral%20form\Nursery%20report%20Final.doc) * Family information form ([mandatory](file:///\\bhtfile01\chi$\Communications%20&%20Media\NEW%20STRUCTURE\COMMS%20VEHICLES\WEBSITE\0000_NEW%20WEBSITE%20for%202021\Microsites\230808_CYP%20Community%20paediatric%20referral%20form\Family%20Information%20Form.doc) for ASD referrals)   **The following would also support your referral (**Please tick which professional are involved and corresponding evidence is included)  Occupational Therapy :  Portage :  Speech and Language therapy :  Reports confirming diagnosis & treatment to date if the child has been seen out of area previously or privately (For children already on medication, they should continue to receive private medication support, for children referred back to the NHS they will be seen in order of waiting times)  Family and social background: (Including employment, relevant health issues, social care, housing etc.)  Hearing 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): | | | | | |
| Contact number 1: | | Contact Number 2: | | | |
| 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/pre-school/childminder: | | | | | |
| **Reason(s) for Referral** (What is the clinical question? What is the background to this? What are your findings on observation/examination?)**:**  Reason for referral (What are the family’s concerns?)  May they need extra provision when they start school, and if so has an early years notification been completed and sent to Buckinghamshire Council? (Email address: [Earlyyearsnotifications@buckinghamshire.gov.uk](mailto:Earlyyearsnotifications@buckinghamshire.gov.uk)) | | | | | |
| **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. | |