**INTEGRATED CHILDRENS THERAPY TEAM REFERRAL FORM**

**(REQUEST for HELP)**

**Occupational Therapy** [ ]  **Physiotherapy** [ ]  **Speech & Language Therapy** [ ]  **Dietetics** [ ]

**Additional forms MUST BE completed for the following:**

* **Speech and Language Therapy (SLT) for communication** [ ]
* **Feeding and Swallowing** [ ]

***All referrals must be completed by a healthcare professional unless referring to***

***Speech & Language Therapy.***

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| **Is this a re-referral?** Yes [ ]  No [ ]  Don’t know [ ]  |
| Child’s name: Address:  | Date of Birth: Male/Female: NHS No: Telephone No:  |
| School/Nursery: Name of Parent/Carer(s): Relationship to child: Who has parental responsibility?  |
| Are there any Safeguarding concerns?Is the child subject to a looked after child review?  |  Yes [ ]  No [ ]  Yes [ ]  No [ ]  |
| If yes, please give further details (include social worker/family support worker details): **If circumstances change following this referral please let the relevant Therapy Team know** |
| GP details: Paediatrician: Other professionals involved:  |
| **What are your concerns?** **Level of concern:** **Family: Low** [ ]  **/ High** [ ]  **Referral Agent: Low** [ ]  **/ High** [ ] **Child/Young person: Low** [ ]  **/ High** [ ]  **/ Not applicable** [ ]  |
| **What do you think the young person and parents want help with?** **If appropriate what do you think school/preschool want help with?**  **As a referrer what do you want help with from the Children’s Therapy Services?**  **Please could you give us some information about how the difficulties are affecting the child’s everyday life at home and at school.**  **What strategies have already been tried at home or at school/preschool to help the child/young person with those difficulties?**  **How are they working?**  **Relevant medical history (medication, weight, height where appropriate) and medical diagnosis:**  *Please attach recent clinic report if available* |
| **Are the child’s abilities (e.g. physical skills; communication skills; learning level):**[ ]  all at the same level, or[ ]  Is one area of development significantly lower than the others? Please state which ability is lower: [ ]  I don’t know |
| Is an interpreter or signer required? YES [ ]  NO [ ]  Service Required: **For Speech & Language Therapy:** Please note an interpreter may be requested for the purposes of language assessment if the child experiences more than one language in their daily life Can parents/carers understand written information? YES [ ]  NO [ ]  |
| Has the parent/carer person been informed and given their consent for this referral?[ ]  YES [ ]  NOFor secondary school aged children, has the young person been informed of this referral and the reason for it? [ ]  YES [ ]  NO |
| Other relevant information (include any previous contact with Therapy team):  |

Please make sure all parts of the form are completed.

Decisions regarding the acceptance of referrals are based on information supplied.

Incomplete forms will be sent back to the referrer for completion prior to the referral being processed by the team.

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| Signed Referrer:  | Designation/Role:  |
| PRINT Name:  | Date:  |
| Address:  | Telephone Number:  |

**Please email completed referral forms to:** **yhs-tr.ChildrenTherapyAdmin@nhs.net**

**Or send by post to:**

**York & Selby Area**

Children’s Therapy Team, Child Development Centre, York Hospital

Wigginton Road, York, YO31 8HE.

**Scarborough Whitby Ryedale Area**

Children’s Therapy Team, Springhill House, Springhill Close, Scarborough, Y012 4AD