|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Therapy Admin Only | Date Received |  | Triaged by: |  |
| Referral Priority |  | Pathway: |  |
| Initial Appointment |  | Date: |  |

**INTEGRATED CHILDRENS THERAPY TEAM REFERRAL FORM**

**Occupational Therapy Physiotherapy Speech and Language Therapy Dietetics**

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

* **Occupational Therapy for Sensory Needs**

* **Speech and Language Therapy (SLT) Feeding and Swallowing**

**(For feeding & swallowing concerns, referrer does NOT need to complete additional SLT form)**

***All referrals must be completed by a healthcare professional unless referring to Speech & language therapy.***

|  |  |
| --- | --- |
| Child’s name: Address:  | Date of Birth: Male/Female:Casenote No: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 NOIf 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:  |
| * **Diagnosis/Reason for referral:** *Please attach recent clinic report if available*
* *Please explain impact of this problem on child/young person’s daily life, inc severity of symptoms:*
* *Relevant medical history (medication, weight, height where appropriate)*
 |
| Do you think there is a discrepancy between the child’s cognitive ability and their functional performance?  YES NO N/A  |
| Specific RequirementIs an interpreter or signer required? YES NO Service Required:Can parent’s/carers access written information YES NO |
| Other relevant information (include any previous contact with Therapy team): |
| Has the parent/carer/child/young person been informed and given their consent for this referral?YES: NO: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 be processed by the team.  |
| Signed Referrer: | Designation:  |
| PRINT Name:  | Date:  |
| Address: | Telephone Number: |

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

Or see theChildren’s AHP Therapy Service Access Routes for York Selby, Scarborough Whitby, Ryedale Flow Chart for base addresses.