Derbyshire Healthcare NHS
NHS Foundation Trust

Children & Young People's Therapy Service

Referral Form

Important:

- Has the child/young person you are referring been seen by our service within the last 12 months? Yes☐ No☐
- Has this referral been discussed with parents? Yes☐ No☐

Parental consent for information gathering from any professional detailed on this form is required in order to process this referral.

Parent name:..... Signature: ..... Date: .....

A. Child's Details

Child's Name			
Date of Birth:		NHS No:	
Address (include post code):			
Parent's/Carer's Name(s):			
Mobile No:		Home No:	

Is the child/young person a Looked After Child? Yes☐ No☐

Preferred Language: ..... Interpreter required? Yes☐ No☐
Ethnic Origin:..... Religion:……..

B. Referrer Details (We only accept referrals from the following sources)

Referrals are taken for triage from the following list (please tick as appropriate):	
General Practitioner (GP) / Consultant Paediatrician / Community Paediatrician / School Doctor	
Occupational Therapy / Physiotherapy / Speech & Language Therapist, Social Care Therapists / CAF	
Specialist Nurses / LD Nurses / Health Visitors	
Special Educational Needs Co-ordinator (SENCO) via Physical Literacy Pathway Process	
Clinical and Educational Psychologist (Not on service spec)	

Referrer Name:			
Job Title		Dept/Organisation:	
Referrer Address:			
Tel No		Mobile:	
Date of Referral:			

C. School Details

School Name:	
Address (Inc. postal code):	
Tel No:	
SENCO:	

D. GP and Consultant Details (If appropriate)

GP Name:		Consultant Name:	
Address:		Address:	
Tel No:		Tel No:	

E. Previous Interventions

Please identify any strategies and advice already tried:	
***Physical Literacy	
Home/School Programmes	
Attending parent education session	
Any other information:	

***NB:** For SENCO referrals, it is compulsory that the child has completed 2x 8week Physical Literacy interventions and little progress has been seen. Please also supply evidence

School Referrals Only: Please attach evidence of strategies used e.g. I.E.P, following training or programmes. Please give reasons why strategies used have not worked and/or what additional support you now require:

(If you would like to provide us with any additional information, please attach)

F. Other Relevant Information

How many weeks gestation was the child/young person born at?		
	Yes	No
Did the child/young person achieve developmental milestones?		
If no, please describe difficulties:		
Does the child/young person have a diagnosis?		
If yes, please give details:		

Are there other professionals involved with the child/young person?			
Name:		Name:	
Profession:		Profession:	
Tel No		Tel No	
Name:		Name:	
Profession:		Profession:	
Tel No		Tel No	

Have any other referrals been made?

G Reason for Referral

Please describe your main concerns for the child/young person in the relevant areas below:

Physical Skills			
Mobility indoor/outdoor/stairs/trips and falls		balance/co-ordination/posture	
P.E.		Movement skills, climbing, walking pattern, moving on/off floor	
Ball Skills			
Please describe main concerns:			

Independence Skills			
Eating/cutlery/drinking		Dressing	
Toileting		Brushing teeth/Hair	
Bathing		Positioning / Seating & Equipment	
Please describe main concerns:			

School Skills			
Organisation of Self		Pencil skills	
Hand dexterity and manipulation		Using Scissors	
Please describe main concerns:			

Referral to Parental Sensory Group			
Noise		Difficulty with clothing	
Touch		Changes in routine	
Tastes		Difficulty with change of environments	
Lights		Highly active or passive	
Movement			
Please describe **main** concerns:			

Other concerns?

What do you want the outcome of our involvement to be?

Level of Anxiety:

Level of anxiety	High	Medium	Low
Parents			
School			
Child			
Doctor			

Referrals received will be triaged and a decision made whether or not the referral meets our service specification criteria.

Acknowledgement regarding referral acceptance will be sent to the referrer, and patient/carer. If the referral is not accepted, it is the referrer's responsibility to liaise with parents/carers.

Please return to:

Community Paediatric Occupational Therapy & Physiotherapy
Cardinal Square
1st Floor – East Point
10 Nottingham Road
Derby
DE1 3QT

Tel: 01332 888080
Extensions: 88371 / 88309 / 88308
Fax: 01332 888122

Please ensure you have completed all sides of the form fully to avoid delay and assist us in processing this referral.

We cannot accept incomplete forms and these will be returned to the referrer.

Thank you

Referral Criteria

Referrals are accepted for children aged 0-18 years (19 if in education).

We accept referrals for children with:

- Physical disability – e.g. Cerebral Palsy, Spina Bifida, neuromuscular conditions, oncology, head injury and acquired disabilities.
- Emerging developmental concerns, including a variety of syndromes.
- Motor co-ordination difficulties.
- Sensory processing difficulties appropriate for the parental sensory group.

A child should not be referred solely because they have particular diagnosis, the child needs to present with functional difficulties which can be addressed to help them reach their full potential.

We do **not** accept referrals for children with:

- Back pain, joint and muscles aches and pains as the only reason for referral
- Juvenile chronic arthritis
- Chronic fatigue
- Medically unexplained illness
- Respiratory difficulties
- Splinting
- Anxiety and separation issues
- Sensory integration treatment
- Pica, and behavioural eating difficulties.