Referral form 2025

Derby and Derbyshire Community Physiotherapy Service

for Children and Young People

|  |  |  |
| --- | --- | --- |
| **Patient Name:** |  | |
| **Date of birth:** |  | |
| **NHS no:** |  | |
| **Address:** |  | |
| **Parent/carer Name and contact number:** |  | |
| **Parental Responsibility** |  | |
| **School/Nursery**  (if applicable)**:** |  | |
| **GP Name and Address:** |  | |
| **Referrer Name and relationship:** |  | |
| **Referrer email:** |  | |
| **Referrer phone number:** |  | |
| **Correct service check** | Please confirm you have checked this service is the correct service for the child/young person’s needs, as there are 2 different NHS Paediatric Physiotherapy services in South Derbyshire, that meet different needs. There may be a delay in physiotherapy assessment if referring to the incorrect service (see link below for more information).  Yes / No (delete as appropriate)  [Requests for Help :: Derbyshire Healthcare NHS Foundation Trust](https://www.derbyshirehealthcareft.nhs.uk/services/childrens-complex-health-derby-and-southern-derbyshire/childrens-occupational-therapy-and-physiotherapy/referrals) | |
| **Reason for requesting physiotherapy** |  | |
| **Follow up call** | Please indicate if a phone call would be helpful if further discussion is required. | Y/N |
| **Goal for physiotherapy intervention**  Please note that a referral will not be accepted if this is not completed |  | |
| **Relevant background information**  (inc. medical history and history of present condition) |  | |
| **Functional impact on daily activity**  (Please explain the impact of the concern on the child or young person’s daily life, including whether this is impacting access to school) |  | |
| **Current support in place (**eg mobility aids, carer support, other health professionals, EHCP) |  | |
| **Referrer level of concern** | Very high (5); high (4); moderate (3); low-moderate (2); low (1) | |
| **Please indicate if patient or parent has consented to referral** | Parent consent: | Y/N |
| Young person consent: | Y/N |
| **Social care involvement and safeguarding information if relevant** |  | |
| **Any other comments** |  | |

Please send referral form to: dmh-tr.therapyenquiries@nhs.net