Referral form 2025

Derby and Derbyshire Community Physiotherapy Service

for Children and Young People

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| **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