**Referrals will be** accepted **from any health, social care/MAT, educational (SENCO) or 3rd sector service via**

**Email:**  **dhcft.SPOA@nhs.net**

**Post:** Temple House Mill Hill Lane, Derby, DE23 6SA

**Tel:**  If you need to discuss a new or existing referral the SPOA Administrator can be contacted on 0300 7900 264.

**Please Note**: The information contained in this form will be used by the Single Point of Access team to identify the most appropriate service to meet the needs of the child. The Information on this referral form shall be used in accordance with the permissions granted by you and in accordance with GDPR and the Data Protection Act 2018. Derbyshire Healthcare NHS Foundation Trust is the Data Controller for the purposes of the Act and can be contacted at Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ. The Data Controller is committed to protecting your privacy and will collect, store, use and share the data when appropriate and only for the purposes relating to this form. For a full explanation and further information on your rights please click the link below to view the Data Controllers Privacy Notice

<https://www.derbyshirehealthcareft.nhs.uk/privacy-policy>

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| **PART A** |
| **Child /Young person’s - Patient details** |  | **Referrer** |
| Forename |  |  | Full Name |  |
| Surname |  |  | Designation |  |
| Address |  |  | Base address |  |
| Postcode |  |  | Telephone no |  |
| Date of birth  |  |  | Email |  |
| NHS number |  |  | Date of referral |  |
| **School nursery details** |  | **GP details** |
| Senco/Keyworker name |  |  | GP name  |  |
| School/nursery name |  | GP practice name |  |
| Address |  | Address |  |
| Contact email |  |
| Telephone  |  |
| Home language |  | Post Code |  |
| Interpreter needed | Yes [ ]  | No [ ]  | Telephone |  |

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| **Family \ carer information** |
| Who looks after the child? | Full Name:  |
|  |
| In what capacity | Birth Parent[ ]  | Adoptive parent [ ]  | Carer [ ]  | Other [ ]  |
|  |
| Who has Parental responsibility to child/young person  | Full Name: |
|  |  |
| Telephone numbers | Home: | Mobile: |
|  |
| Email  |  |
| Address if different to the child/ young person |  |
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| **Consent - Please ensure you complete this section as the referral will be rejected without completed consent.** |
|  | **Yes** | **No** |
| Parental/ Carer consent given for this referral? **The referral will be returned if consent is not gained.** |[ ] [ ]
| Parental/ Carer consent given for access to the child’s paper and electronic health records? **The referral will be returned if consent is not given.** |[ ] [ ]
| Child/ Young Person consent given for this referral (if applicable/ appropriate) |[ ] [ ]
| Parental/Carer consent for the current professional responsible for my child's care to communicate with any other health professionals and organisations from the past or present.*If* ***no****, please specify:* |[ ] [ ]
| Consent for the professional involved in my child’s care to visit my child at school/nursery for short-notice appointments, without my specific consent each time. |[ ] [ ]
| Consent for the professional involved in my child’s care to email the parent//carer personal information about their child.*If* ***yes****, please state parent email address:* |[ ] [ ]
| Parental/Carer consent to receive SMS text messages for correspondence/reminders for appointments. *If* ***yes,*** *please state preferred mobile number.* |[ ] [ ]
| Parental/Carer consent to this referral being signposted to the most relevant agencies if deemed inappropriate for Community Paediatrics or the Neurodevelopmental Pathway (This may include, mainstream CAMHS School Nursing, Learning/Intellectual Disability Services, Speech and Language Therapy). |[ ] [ ]
| **PART B** |
| **Referral information** |
| Reason for referral:  |
| **If the referral is for a neurodevelopmental assessment for autism spectrum disorder (ASD) or ADHD, please indicate this: Tick the relevant box/es.****NB:** We do not accept referrals for ADHD assessment if under 5 ½ years old. | Autism spectrum disorder [ ] ADHD (if over 5 ½ years old) [ ]  Consent to place on a different pathway if appropriate [ ]  |
|  |
| **Development and Skills** |
| **Please give details of practitioner and parent/carer current or previous concerns** |
| Motor skills (Gross motor and fine motor) |  |
| Speech and Language |  |
| Personal and Social skills- |  |
| Academic Skills |  |
| Any regression of development |  |

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| **Specific concerns** |
| Abuse [ ]  | Self-harm [ ]  | Hyperactivity [ ]  |
| Anxiety/phobias [ ]  | Low mood [ ]  | Poor concentration [ ]   |
| Attachment needs [ ]  | Obsession +/- compulsions with fear [ ]  | Social/communication difficulties [ ]  |
| Post trauma symptoms [ ]  | Stress [ ]  | School exclusion or threat of [ ]  |
| Bereavement [ ]  | Parental mental health needs [ ]  | Learning needs/disability- if ticked, please enclose assessments done [ ] [ ]  |
| Eating/weight difficulties [ ]  | Vocal or motor tics [ ]  | Behavioral problems [ ]  |
| Family breakdown [ ]  | Suicidal thoughts/threats [ ]  | Physical disability [ ]  |
| Hearing voices [ ]  | Substance misuse [ ]  | Peer bullying [ ]  |

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| **Details of above concerns and anything else you think we should know** |
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| **Safeguarding** |
| *Are any of the following in place for the child? (Please provide copies)* |
| Early Help Assessment (EHA)  |[ ]  Child in need support |[ ]
| Child protection plan  |[ ]  Child looked after by the Local Authority |[ ]
| Does the patient or family have any safeguarding concerns? *(If yes, please specify)* |
| **Social and family history - Include parents, siblings, relevant family circumstances and any known risks.**  |
| *Please fill in Detail Section in addition to ticking boxes* |
| Identified SEND  |[ ]  Education Health and Care Plan |[ ]  GRIP funding |[ ]
| Parent mental health concerns |[ ]  Parent physical health concerns |[ ]  Sibling physical health concerns |[ ]
| Parent disability |[ ]  Sibling disability | ☐ |  |  |
| Substance abuse |[ ]  Domestic abuse |[ ]   |  |
|  |
| **Support provided** |
| ***Please provide evidence of support offered by universal services and graduated response prior to referral to specialist services, or the referral will be returned*** |
| Parenting course  | [ ]  | Early help assessment |[ ]
| Education- Graduated response |[ ]  Other |[ ]
| **Details of concerns:** Please give details of practitioner and parent/carer concerns.Please include details on:* Current concerns
* How long the concerns have been present for
* How may these difficulties affect the child or young person in their daily life?
 |  |
| What interventions have been tried to address the concerns described?  |  |
| Medical history, including any specific assessment which may have already been completed and specific diagnoses already known: |  |
| Details of any current medication |  |
| Any known allergies? If yes, please give details. |  |

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| **Neurodevelopmental referral (i.e., concerns about possible autism spectrum disorder and/or ADHD)** **Note to referrer:** To enable the professionals to make appropriate decisions please ensure you have enclosed the following paperwork with this referral. Failure to do so will result in the referral being returned.1. Parent/carer questionnaire completed

[**FORM 4 \_ JUCD Neurodevelopmental Pathway Parent\_Carer Questionnaire Final V4.docx**](https://www.derbyshirehealthcareft.nhs.uk/download_file/7079/0)1. Pre School OR School questionnairecompleted

[**FORM 2\_ JUCD Neurodevelopmental Pathway Pre school Questionnaire Final V3.docx**](https://www.derbyshirehealthcareft.nhs.uk/download_file/7077/0)[**FORM 3\_JUCD Neurodevelopmental Pathway Child Young Persons School Questionnaire.docx**](https://www.derbyshirehealthcareft.nhs.uk/download_file/7078/0) |
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