NCH&C Referral Form
Children and Young People's (CYP) Community Children Health Services

- Please complete ALL relevant parts of this form and include/attach all relevant information and details in support of the referral. This will enable clinical screening and ensure the needs of the child or young person will be met by the most appropriate service or services within NCH&C.
- All sections are **Mandatory**

One referral form to be filled in for each child that is being referred

Date of referral	

Section 1 - Key information about the Child/Young Person

Surname of CYP		☐ Male / ☐ Female	Date of birth:	
First name of CYP		NHS No		
Home address and postcode:		Home telephone no:		
		Work telephone no:		
		Mobile telephone no:		
Child's preferred first language:	language not specified	Religion:	Ethnic Origin:	
Education: (Please include which School/College CYP attends and whether or not this is on a full or part time schedule)				

Is the child/young person a Looked After Child?	☐ Yes	☐ No
Is the child/young person Adopted?	☐ Yes	☐ No
Does the child/young person have a Child Protection Plan?	☐ Yes	☐ No
If **yes**, is the Child Protection Plan attached?	☐ Yes	☐ No
Does the child/young person have an Education Health and Care (EHC) Plan?	☐ Yes	☐ No
If **yes**, is the EHC attached?	☐ Yes	☐ No
Does the child/young person have a disability?	☐ Yes	☐ No
If **yes**, please give more detail:		
Does the child have a diagnosed learning disability?	☐ Yes	☐ No
If **yes**, what is the diagnosis?		
Does the child have a physical disability?	☐ Yes	☐ No
If **yes**, please give more detail:		
Does the child already have a diagnosis?	☐ Yes	☐ No
If **yes**, what is the diagnosis?		
Are there any safeguarding concerns?	☐ Yes	☐ No
If **yes**, please give more detail:		

If there is a safeguarding concern, is the child/young person known to social care?	☐ Yes	☐ No
Please give name of Social Worker, if known?		
Is there an Early Help assessment and plan (EHAP) in place?	☐ Yes	☐ No
If **yes**, is the EHAP attached?	☐ Yes	☐ No

Is there a Family Support Plan in place?	☐ Yes	☐ No	Attached	☐ Yes	☐ No

Section 2 – Household details			
Surname	**Forename**	**Relationship to CYP**	**Parental responsibility for CYP?**
			☐ Yes / ☐ No
			☐ Yes / ☐ No
			☐ Yes / ☐ No
			☐ Yes / ☐ No
			☐ Yes / ☐ No

Details of Parent/Carer and other person(s) with Parental Responsibility who live outside of the household				
Surname	**Forename**	**Address**	**Tel. No.**	**Relationship to CYP**

Section 3 - Referrer's Information		
Name		Address and postcode:
Job title/role		
Agency/organisation		
Contact number		
E-mail address		

Section 4 - GP details if not the referrer			
Name of GP		Practice Name	**Orchard Surgery**
Address	Orchard Surgery	Secure email address	
Postcode	NR19 1AE	Contact number	**01362 692916**

Section 5 - Service(s) requested

Please indicate the service(s) delivered by NCHC you expect are required to support the needs of the child/young person.

Children's Community Nursing

We have a **Children's Community Nursing team**, a **Paediatric Nurse Advisor service**, a **Short Breaks Home Nursing service**, a **Short Breaks Residential service (Squirrels), the Children's Epilepsy team** and the **Children's Continence team**.

Please see page 1 and 2 of the NCH&C Referral Form Guidance for more information

Children's Community Nursing Team Please add Name and contact details of Paediatric Consultant:	☐
Paediatric Nurse Advisor	☐
Short Breaks – Home Based Nursing Team Children aged 0-18 years for regular short breaks at home, 3-4 hours per week	☐

Short Breaks Residential (Squirrels)
Children aged 8-18 years in a 4 bedded unit ☐

The Children's Epilepsy Nursing Service ☐

Please tick relevant boxes

Newly diagnosed Patient	☐	Admission with an increase/change in seizures	☐
Prolonged seizure requiring Buccal Midazolam prescription	☐	Informing of a hospital admission	☐
Under investigation for possible seizures – requires telephone support	☐	Other	☐

Buccal Midazolam Referrals

Training has been provided to parent/carer	☐	Prescription given	☐
Parent/Carer aware to call 999 for first administration	☐	How to administer Buccolam leaflet given	☐

Children's Continence service ☐
Referrals without a completed level one continence assessment will be rejected

Children's Occupational Therapy (0-18years) ☐

Community Paediatrics up to the 6th birthday for developmental concerns ☐

Please see page 3 of the NCH&C Referral Form Guidance for more information

Community Paediatrics 0-18 years (complex needs 0–19) ☐

Please see page 3 of the NCH&C Referral Form Guidance for more information

Key Worker Service ☐
Please see page 4 of the NCH&C Referral Form Guidance for more information

Neurodevelopmental Service (NDS) ☒
Neurodevelopment concerns e.g., ASD, ADD or ADHD for children aged 6 years and over

Please ask families to complete the Parent Observational Questionnaire and request that school complete the Teacher observational Questionnaire as well as providing supporting evidence and enclose this with your referral. Referrals without the TOQ and POQ may be rejected if there is insufficient evidence of Neurodevelopmental difficulties within the referral document from GP and school.

Please see page 5 of the NCH&C Referral Form Guidance for more information

Starfish - Children's LD CAMHS ☐

Referrals without evidence of a learning disability will be returned to the referrer.

Please see page 6 of the NCH&C Referral Form Guidance for more information

More information about these services can be found on the Norfolk Community Health and Care Trust website: https://www.norfolkcommunityhealthandcare.nhs.uk/childrens-services

Section 6 - Professionals Involved

Which other professionals are already involved with this child/young person?

Start Date	Agency	Name & Role	Telephone contact/email

Section 7 - Reason(s) for referral

Section 8 - Referral Information

What is the problem you have identified for the child/young person?
Areas to think about: child's functioning in home/school and with peers. Where possible please provide specific examples.

Please outline any strategies that have been used to help the child/young person

Relevant History
Please include key areas of concern (e.g. history of difficulties, medical history, allergies, developmental history, family structure)

What is life like for the family?
Areas to think about – family history, circumstance and functioning, family members, family health and wellbeing, housing, employment, money, violence in the household, social integration, and community resources where they live, history of significant events, support networks? Cover strengths as well as risk factors

Section 9 - Are further information/reports attached to this referral? ☐ Yes / No ☐

If yes, please state which reports or info is attached.

Section 10 - Consent

Young Person (16+) consent - if the young person is unable to consent then this should be evidenced with the Mental Capacity Act assessment:

I agree that this assessment is an accurate summary of my situation and understand that the information in this assessment will be shared with professionals and services within Norfolk Community Health and Care.

Information may also be shared with other agencies outside of Norfolk Community Health and Care in support of providing me and my family with the right care.

Name:	Signature	Date:

Parental Responsibility consent

I/ we agree that this assessment is an accurate summary of my / our family situation and understand that the information in this assessment will be shared with professionals and services within Norfolk Community Health and Care.

Information may also be shared with other agencies outside of Norfolk Community Health and Care in support of providing me and my family with the right care.

Name: Relationship to the Child / Young Person:

Signature: Date:

If there are any parts of the assessment that you do not wish to be shared, please state here which section and services you would not want it to be shared with:

Consent to receive text messages – please ensure mobile contact is provided Mobile number:	☐ Yes / No ☐
Consent to receive emails – please ensure email address is provided Email address:	☐ Yes / No ☐

Section 11 – Single Point of Referral (SPoR) Contact Details

Please send the completed referral form via e-mail to childrenscommunityreferrals@nchc.nhs.uk

Please add in the subject line of the email: **Referral to "add service name" for "add child's initials"**

Any queries please call 01603 508958

Medical Problems:

Medication:

Allergies:

Safeguarding concern? Please call Children's Advice and Duty Service (CADS) via 0344 800 8020