# Referral form

### Please read before completing this form

Children and Family Health Devon can support children and young people through the provision of specialist advice, guidance, assessment, diagnosis, care and treatment (as appropriate). We ask that you complete this form so that we can understand whether and how we can best meet the needs of the child / young person.

## (1) Consent

|  |  |  |
| --- | --- | --- |
| Has the child / young person consented to this referral | Yes | No |
| Has the parent / carer with parental responsibility consented to this referral | Yes | No |
| If no, please provide details why not  *Please note: We can only process a request for help when we have consent from the person(s) with parental responsibility if child is under 16 years* | Yes | No |
|  |  |  |

## (2) Referred by

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Job title / relationship to child |  |

## (3) Information about the child / young person

|  |  |  |
| --- | --- | --- |
| Surname |  | |
| Forenames |  | |
| Preferred name |  | |
| Date of Birth |  | |
| NHS Number (if known) |  | |
| Ethnicity  *We ask this information to enable us to monitor whether our services are being accessed by all sections of our communities* |  | |
| Nationality |  | |
| Religion |  | |
| Sex at birth | Male | Female |
| Gender identity |  | |
| Pronouns |  | |
| Preferred language |  | |
| Interpreter needed? |  | |
| Address |  | |
| Postcode |  | |
| Parent / carer email |  | |
| Tel: Parent /carer (Home / Mobile) |  | |
| Young person email |  | |
| Tel: Young person (Home / Mobile) |  | |

## (3) Information about the child / young person (continued)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please select the parent/carers preferred way(s) of communication. | | | | Phone | Email | | Post | | Other |
| Please select the young person’s preferred way(s) of communication | | | | Phone | Email | | Post | | Other |
| Has the child been referred to Children and Family Health Devon in the past | | | | Yes | No | | Unsure | | |
| If **YES** please provide details | | | | Type your response here. | | | | | |
| **Main Carer(s)** | Parent | Mother | | | | Father | | Grandparent | |
| Guardian/Other | Step Parent | Foster Carer | | | | Resident Key Worker | | | |
| **Name** | | |  | | | | | | |
| Parent Responsibility | | |  | | | | | | |
| Relationship to the above | | |  | | | | | | |
| Address if different | | |  | | | | | | |
| **Name** | | |  | | | | | | |
| Parent Responsibility | | |  | | | | | | |
| Relationship to the above | | |  | | | | | | |
| Address if different | | |  | | | | | | |
| **Name** | | |  | | | | | | |
| Parent Responsibility | | |  | | | | | | |
| Relationship to the above | | |  | | | | | | |
| Address if different | | |  | | | | | | |

## (4) Access needs

## Does the child/young person / family need any adjustments in order to access the service

|  |  |
| --- | --- |
| Any access needs due to disability or health? *e.g. Learning disability, communication, developmental, physical or medical needs* |  |
| Please specify |  |

## (5) GP Details

|  |  |
| --- | --- |
| Name |  |
| Address (including postcode) |  |
| Telephone |  |

## (6) Nursery / School / College details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | | | |
| Addresses  *(including postcode)* |  | | | |
| Telephone |  | | | |
| Extra learning support in education / setting | Yes | No |  |  |
| If **YES** please give details |  | | | |
| Special Education Needs and Disabilities (SEND) Support / Register | Yes | No |  |  |
| If **YES** please give details and attach plan |  | | | |
| Education, Health, Care Plan (E HCP)? | Yes | No |  |  |
| If **YES** please give details and attach plan |  | | | |
| Is the child / young person in alternative provision? | Yes | No |  |  |
| Is the child / young person electively home educated? | Yes | No |  |  |
| If **YES** please give details |  | | | |
| Not in Education, Employment or Training? | Yes | No |  |  |
| If **YES** please give details |  | | | |

## (7) Do any of the following apply to the child / young person?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Early Help Assessment? | Yes - currently | Previously | No | |
| Team around family meetings? | Yes - currently | Previously | No | |
| Early Help Assessment? | Yes - currently | Previously | No | |
| Has the child or young person been adopted? | Yes - currently | Previously | No | |
| Registered as a looked after child? | Yes - currently | Previously | Don’t know | No |
| Identified as a Child in Need? | Yes - currently | Previously | No | |
| Child Protection Plan | Yes - currently | Previously | No | |
| Any safeguarding concerns? | Yes - currently | Previously | No | |
| Legal proceedings | Yes - currently | Previously | No | |
| Legal order/s | Yes - currently | Previously | No | |
| Hospital | Yes - currently | Previously | No | |

|  |
| --- |
| If answering yes, please provide details and attach any relevant reports: |

### Reason for referral Please refer to CFHD Access Criteria

Where indicated, please complete the additional information form **as well as this** general referral form

|  |  |
| --- | --- |
|  | Neurodiversity (Assessment Autism only) – Neurodiversity Additional Form |
|  | Physical Disability – Physical & Sensory additional information |
|  | Chronic pain and fatigue |
|  | Mental Health |
|  | Developmental delay - Physical & Sensory additional information |
|  | Eating disorder – Eating Disorder additional form |
|  | Learning disability – Learning Disability questions |
|  | Movement – Physical & Sensory additional information |
|  | Complex Physical Health – Community Children Nursing questions |
|  | Sensory - Physical & Sensory additional information |
|  | Speech, language and Communication – Speech, Language and Communication additional questions |
|  | Swallowing difficulties – Dysphagia questions |
|  | Behaviour |
|  | Unsure |

Please describe why you are seeking a service for the child / young person: what is the nature and background of the problem, including:

|  |  |
| --- | --- |
| Frequency / intensity of difficulties | Type your response here. |
| How long the difficulties have been occurring? | Type your response here. |

### Reason for referral (continued) Please refer to CFHD Access Criteria

|  |  |
| --- | --- |
| How this is impacting on day to day functioning? |  |
| Any significant concerns, risks / safety issues related to the child / young person’s health need? Include details of risks of harm to self or others, neglect, exploitation or physical health |  |
| Any existing diagnoses; who has made the diagnoses / include dates. Include any physical health, mental health or neurodiversity diagnosis and important medical history |  |
| If the child / young person is in hospital  a) is there a discharge planning meeting arranged? |  |
| b) What is the planned date of discharge? |  |
| Any stressful events in the family or in the young person’s life that are helpful for us to know about |  |
| Any other significant concerns or health problems that have affected the child / young person / family |  |
| What is your assessment of the difficulties? |  |
| How can CFHD help? What outcome would you hope to achieve from accessing help from CFHD? |  |
| Please describe any previous or current guidance, self-help, peer support / professional support or treatment the child has received to address the problem. Has this been helpful? What has worked well? |  |

(8) Professionals involved with the child   
(Please state details including name and contact if known)

|  | **Past involvement** | Current involvement |
| --- | --- | --- |
| **Health professionals** |  |  |
| General Practitioner (GP) |  |  |
| Paediatrician |  |  |
| Speech & Language Therapy |  |  |
| Physiotherapy |  |  |
| Occupational Therapy |  |  |
| Children’s Nursing |  |  |
| CAMHS |  |  |
| Mental Health Support in Schools |  |  |
| Learning Disability support |  |  |
| Neuro-diversity Key Worker |  |  |
| School Nurse |  |  |
| Health Visitor |  |  |
| Dietician |  |  |
| Bladder and Bowel service |  |  |
| Visual / hearing impairment services |  |  |
| Wheelchair / mobility equipment |  |  |
| Equipment service |  |  |
| Adult Mental Health services |  |  |
| Educational Psychology |  |  |

(8) Professionals involved with the child (continued)  
 (Please state details including name and contact if known)

|  |  |  |
| --- | --- | --- |
|  | **Past involvement** | Current involvement |
| **Education services** |  |  |
| Specialist school staff e.g. SENCO / Autism Champion / counsellor |  |  |
| Early Years Inclusion service e.g. Portage, EYCN |  |  |
| **Social Care Services** |  |  |
| Social Worker |  |  |
| Family Support Worker /  Early Help |  |  |
| Youth Justice Service |  |  |
| **Police** |  |  |
| Community Support - Police |  |  |
| Other community organisations e.g. Voluntary sector / Community Interest Company |  |  |
| Others – please list below: |  |  |

Strengths

|  |  |
| --- | --- |
| Please describe the young person’s / family’s strengths to address the problem |  |

Barriers / challenges in accessing help or resolving the issues

|  |  |
| --- | --- |
| What barriers / challenges might prevent you / the child / the family accessing help or working to resolve the issues? |  |

(9) Signed

|  |  |
| --- | --- |
| Date of referral |  |
| Signed |  |
| Name and job title / relationship to child |  |

Once completed please send this form and accompanying documentation to our   
Single Point of Access

**Preferably by email:** [cfhd.devonspa@nhs.net](mailto:cfhd.devonspa@nhs.net)

**Or by post:**

Children and Family Health Devon, Single Point of Access Team, 1a Capital Court,  
Sowton Industrial Estate, Exeter, EX2 7FW