# 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 |
| Type your response here. |  |  |

## (2) Referred by

|  |  |
| --- | --- |
| Name | Type your response here. |
| Address | Type your response here. |
| Email address | Type your response here. |
| Job title / relationship to child | Type your response here. |
| Date of referral | Type your response here. |
| Signed | Type your response here. |

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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname | | | | | Type your response here. | | | | | | |
| Forenames | | | | | Type your response here. | | | | | | |
| Preferred name | | | | | Type your response here. | | | | | | |
| Date of Birth | | | | | Type your response here. | | | | | | |
| NHS Number (if known) | | | | | Type number here. | | | | | | |
| Ethnicity  *We ask this information to enable us to monitor whether our services are being accessed by all sections of our communities* | | | | | Type your response here. | | | | | | |
| Nationality | | | | | Type your response here. | | | | | | |
| Religion | | | | | Type your response here. | | | | | | |
| Sex at birth | | | | | Male | | | | Female | | |
| Gender identity | | | | | Type your response here. | | | | | | |
| Pronouns | | | | | Type your response here. | | | | | | |
| Preferred language | | | | | Type your response here. | | | | | | |
| Interpreter needed? | | | | | YES or NO response. | | | | | | |
| Address | | | | | Type your response here. | | | | | | |
| Postcode | | | | | Type your response here. | | | | | | |
| Tel: Young person (Home / Mobile) | | | | | Type your response here. | | | | | | |
| Email: Young person | | | | | Type your response here. | | | | | | |
| Please select the young person’s preferred way(s) of communication | | | | | Phone  Email  Post  Other | | | | | | |
| Parent / carer email | | | | | Type your response here. | | | | | | |
| Tel: Parent /carer (Home / Mobile) | | | | | Type number here. | | | | | | |
| Young person email | | | | | Type your response here. | | | | | | |
| Tel: Young person (Home / Mobile) | | | | | Type number here. | | | | | | |
| 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 | | | | | |
| **Main Contact Name** | | | Type your response here. | | | | | | | | | |
| Parent Responsibility | | | YES or NO response. | | | | | | | | | |
| Relationship to the above | | | Type your response here. | | | | | | | | | |
| Address (if different) | | | Type your response here. | | | | | | | | | |
| Telephone number (if different) | | | Type your response here. | | | | | | | | | |
| Email address (if different) | | | Type your response here. | | | | | | | | | |
| Preferred communication method | | | Phone  Email  Post  Other | | | | | | | | | |
| **Name** | | | Type your response here. | | | | | | | | | |
| Parent Responsibility | | | YES or NO response. | | | | | | | | | |
| Relationship to the above | | | Type your response here. | | | | | | | | | |
| Address if different | | | Type your response here. | | | | | | | | | |
| Telephone number (if different) | | | Type your response here. | | | | | | | | | |
| Email address (if different) | | | Type your response here. | | | | | | | | | |
| **Name** | | | Type your response here. | | | | | | | | | |
| Parent Responsibility | | | YES or NO response. | | | | | | | | | |
| Relationship to the above | | | Type your response here. | | | | | | | | | |
| Address if different | | | Type your response here. | | | | | | | | | |
| Telephone number (if different) | | | Type your response here. | | | | | | | | | |
| Email address (if different) | | | Type your response here. | | | | | | | | | |

## (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* | YES or NO response. |
| Please specify | Type your response here. |

## (5) GP Details

|  |  |
| --- | --- |
| Name | Type your response here. |
| Address (including postcode) | Type your response here. |
| Telephone | Type number here. |
| Email | Type your response here. |

## (6) Nursery / School / College details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Type your response here. | | | |
| Addresses  *(including postcode)* | Type your response here. | | | |
| Telephone | Type your response here. | | | |
| Email | Type your response here. | | | |
| Extra learning support in education / setting | Yes | No |  |  |
| If **YES** please give details | Type your response here. | | | |
| Special Education Needs and Disabilities (SEND) Support / Register | Yes | No |  |  |
| If **YES** please give details and attach plan | Type your response here. | | | |
| Education, Health, Care Plan (E HCP)? | Yes | No |  |  |
| If **YES** please give details and attach plan | Type your response here. | | | |
| 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 | Type your response here. | | | |

## (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:  Type your response here. |

### 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? | Type your response here. |
| 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 | Type your response here. |
| Any existing diagnoses; who has made the diagnoses / include dates. Include any physical health, mental health or neurodiversity diagnosis and important medical history | Type your response here. |
| If the child / young person is in hospital  a) is there a discharge planning meeting arranged? | Type your response here. |
| b) What is the planned date of discharge? | Type your response here. |
| Any stressful events in the family or in the young person’s life that are helpful for us to know about | Type your response here. |
| Any other significant concerns or health problems that have affected the child / young person / family | Type your response here. |
| What is your assessment of the difficulties? | Type your response here. |
| How can CFHD help? What outcome would you hope to achieve from accessing help from CFHD? | Type your response here. |
| 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? | Type your response here. |

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

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

(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 | Type your response here. | Type your response here. |
| Early Years Inclusion service e.g. Portage, EYCN | Type your response here. | Type your response here. |
| **Social Care Services** |  |  |
| Social Worker | Type your response here. | Type your response here. |
| Family Support Worker /  Early Help | Type your response here. | Type your response here. |
| Youth Justice Service | Type your response here. | Type your response here. |
| **Police** |  |  |
| Community Support - Police | Type your response here. | Type your response here. |
| Other community organisations e.g. Voluntary sector / Community Interest Company | Type your response here. | Type your response here. |
| Others – please list below: | Type your response here. | Type your response here. |

Strengths

|  |  |
| --- | --- |
| Please describe the young person’s / family’s strengths to address the problem | Type your response here. |

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? | Type your response here. |

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