



REFERRAL FORM COMMUNITY PAEDIATRICS

Please note the referral form will not be accepted without the following:

- All sections of the referral form must be completed
- Child/Young Person must have a Solihull based GP
- Nursery and/or School information for Child/Young Person must be provided

Referral criteria:

- Children and Young People (C/YP) must:
- Have a GP under the Solihull CCG
- Be under 18 years of age unless in a special school in which case 19 years of age
- Be referred by their GP, healthcare professional or school, except for child protection assessments when referrals are accepted from Social care, of from EHCP assessments from the Start team
- Inclusion Criteria
- We accept C/YP with possible or confirmed ADHD at school age with complicating factors such as Autism.
 For cases without complications refer to the ADHD nursing service.
- Children with developmental delay global or isolated requiring medical evaluation and/or intervention
- C/YP with suspected or confirmed abuse or neglect (see below)
- C/YP needing coordination of care for EHCP
- C/YP with palliative care needs
- C/YP with medical complications of neurodevelopmental conditions, including tics, dyspraxia, sleep issues and constipation
- In addition we provide medical support for adoption and fostering services
- Exclusion Criteria
- We do not accept referrals for C/YP:
- Needing assessment for possible Autism (Education service and parent to refer to Specialist Assessment Service)
- Requiring behaviour management unless an underlying neurodevelopmental condition is suspected
- Requiring management of conditions such as anxiety whether or not associated with Autism
- Requiring General Paediatric input without developmental problems
- Pre-school with suspected ADHD -follow the preschool pathway (available on request)
- Suspected Child Sexual Abuse, discuss with Mountain Healthcare
- Isolated Dyslexia
- Isolated Enuresis

Child or young person being referred						
Surname of Child/Young Person: Click or tap here to enter		First Name(s): Click or tap here to				
text. ssssscs		enter text.				
Date of Birth: Click or tap here to enter text.	Birth: Click or tap here to enter text. NHS No: Click or tap					
Address: Click or tap here to enter text.						
Postcode: Click or tap here to enter text.						
Male □ Female □						
Details of Parent/Carer						
Parent/Carer's Name(s): Click or tap here to enter	text.					
Relationship to child: Click or tap here to enter text.						
Parental Responsibility: Mother Yes ☐ No ☐	Father	Yes □ No □				
Address (if different from above): Click or tap here to enter text.						
Daytime Contact Number/ Mobile(please ensure this is up to date): Click or tap here to enter text.						
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Email: Click or tap here to enter text.						

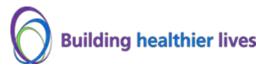




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Details of any current diagnosis/medication				
Click or tap here to enter text.				
Details of School	Details of G.P.			
Name of School:	Name and Practice Address:			
Click or tap here to enter text.	Click or tap here to enter text.			
Telephone number:				
Click or tap here to enter text.				
·				
Child Protection Details (if any)				
Child Protection PlanYo	es ⊔ No ⊔ Unknown ⊔			
Is the child in the care of the Local Authority: Yo	es 🗆 No 🗆			
is the crime in the care of the Local Additionty.				
Type of Care Order: Click or tap here to enter to	ext.			
Consent/Information Sharing				
	aware that information detailed in referrals made to			
Children and Families Division Services may be shared with other health professional and external				
agencies such as Education and Social Care. Has the person with legal responsibility consent	ed to this referral and sharing of information?			
That the percent with legal responsibility contents	od to this relevant and charming of information.			
Yes ☐ If consent has not been obtained this	referral cannot be accepted. Please tick box if			
parents/carers have consented.				
Referrer Details				
Referred by: Click or tap here to enter text.	Signed: Click or tap here to enter text.			
Designation or Relationship to Child:				
Click or tap here to enter text.				
Poterror's full contact address, postcode, talanh	nono:			
Referrer's full contact address, postcode, telephone: Click or tap here to enter text.				
chart of tap horo to office toxt.				

IMPORTANT: Is the child currently being seen by:					
Professional	Name	Contact Tel No	Base		
Health Visitor	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.		
Social Worker	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.		



Medical Consultant

Others, e.g. Specialist

Assessment Service,



text.

text.

Click or tap here

Click or tap here

to enter text.

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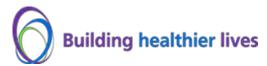
enter text.

SOLAR, SALT, Physiotherapy, OT, Dietetics, Educational Psychology, SENCO, PSS,							
SISS etc.							
Early developmental history	ory/school						
Any concerns at Nursery or school? Yes □ No □							
If yes, please give details a ADHD.	ınd include completed	Vanderbilt's if cor	ncerns relate to possible				
Click or tap here to enter text.							
What age were concerns noted: Click or tap here to enter text.							
Reason For Referral							
Current situation, please d examples of incidents or e (school), self esteem, emot	events which are hav	ing an impact on					
Click or tap here to enter te	ext.						
Other influences impacting relevant correspondence		iculties. Please	describe or enclose				
Click or tap here to enter te	ext.						
Ethnicity Category							
Ethnicity: Click or tap here	to enter text.						
Home Language: Click or t	ap here to enter text.	Is an Interpro	eter required? Yes 🗆 No	э 🗆			
Will carers have any difficu	Ities reading appointm	ent letters	∕es □ No □ Don't Know				

Please send completed referral Via Email to (Preferred option): uhb-tr.communitypaediatricteam@nhs.net

To send via post please send to:

Dr Thangavelu Community Paediatrics Friars Gate, 3rd Floor





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1011 Stratford Road Solihull B90 4BN