Building healthier lives

University Hospitals Birmingham NHS
NHS Foundation Trust

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 text. ssssscs	First Name(s): Click or tap here to enter text.
Date of Birth: Click or tap here to enter text.	NHS No: Click or tap here to enter text.
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. 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: Click or tap here to enter text. Telephone number: Click or tap here to enter text.	Name and Practice Address: Click or tap here to enter text.
Child Protection Details (if any)	
Child Protection Plan ..... Yes ☐ No ☐ Unknown ☐ Is the child in the care of the Local Authority: Yes ☐ No ☐ Type of Care Order: Click or tap here to enter text.	
Consent/Information Sharing	
It is important to ensure that the parent/carer is 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 consented to this referral and sharing 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.	
Referrer's full contact address, postcode, telephone: Click or tap here to enter text.	

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.

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Medical Consultant	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Others, e.g. Specialist Assessment Service, SOLAR, SALT, Physiotherapy, OT, Dietetics, Educational Psychology, SENCO, PSS, SISS etc.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Early developmental history/school

Any concerns at Nursery or school? Yes ☐ No ☐

If yes, please give details and include completed Vanderbilt's if concerns relate to possible ADHD.

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 describe what is happening and when, frequency, duration – giving examples of incidents or events which are having an impact on physical health, education (school), self esteem, emotional well being, relationships.

Click or tap here to enter text.

Other influences impacting on the current difficulties. Please describe or enclose relevant correspondence

Click or tap here to enter text.

Ethnicity Category

Ethnicity: Click or tap here to enter text.

Home Language: Click or tap here to enter text. **Is an Interpreter required?** Yes ☐ No ☐

Will carers have any difficulties reading appointment letters Yes ☐ 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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