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**
* **School information for Child/Young Person must be provided**

|  |
| --- |
| **Child or young person being referred** |
| Surname of Child/Young Person: Click or tap here to enter text. | 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. |
| **Details of any diagnosis/medication/surgeries etc from birth – to date** |
| 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 [ ]  **Please tick box if consent has been gained. If consent has not been obtained this referral cannot be accepted.** |
| **Referrer Details** |
| Referred by: Click or tap here to enter text.(please print name): Click or tap here to enter text. | Signed:  |
| 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 |
| 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 | 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, SISS, SEMH etc. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**ADHD NURSE LED SERVICE** – (Attention Deficit Hyperactivity Disorder)

|  |
| --- |
| **Early developmental history/school**  |
| Any concerns at school? Please note we only accept referrals for school aged children.Yes [ ]  No[ ]  **What age were concerns noted:** 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 referrals via email to:** soladhd.nursingteam@uhb.nhs.uk

**(Preferred option)**

**OR**

**Via Post to**:

**ADHD Clinical Nurse Specialist/Team Lead**

**Community Paediatrics**

**Friars Gate, 3rd Floor**

**1011 Stratford Road**

**Solihull B90 4BN**

***Referral form revised September 2024***





|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |
| --- | --- | --- |
| **Date sent (by school):** | Click or tap here to enter text. | **ADHD Nurse Team and**  |
|  |  | **Community Paediatrics** |
| **Date received (by team):** | Click or tap here to enter text. | Friars Gate, 3rd Floor |
|  |  | 1011 Stratford Road |
|  |  | Solihull |
|  |  | B90 4BN |

|  |
| --- |
|  ADHD Office: 0121 746 4453Paediatrics Office: 0121 746 4455Soladhd.nursingteam@uhb.nhs.ukcommunitypaediatricians@uhb.nhs.uk |

 |

|  |
| --- |
| **ADHD Referral - Secondary Education Document.**Thank you for referring this child to our service for an ADHD assessment. If you could please take the time to complete this document, the information you provide will help us with our assessment of the child. The child’s parents should have given you consent for the referral and enable the service to collect the information from you.All core subject teachers (e.g. Maths, English & Science) and parents must complete a SNAP-IV Questionnaire. |

**Child’s Name:** Click or tap here to enter text.

**Date of Birth:** Click or tap here to enter text. **Age:** Click or tap here to enter text.**Years** Click or tap here to enter text.**Months**

**NHS Number:** Click or tap here to enter text. **Gender:** Click or tap here to enter text.

**Male/Female:** Click or tap here to enter text.

**Name of School:** Click or tap here to enter text.

**Year/Grade:** Click or tap here to enter text.

**Person completing the form**:

|  |  |
| --- | --- |
| **SIGNATURE** |  |
| **PRINT NAME** | Click or tap here to enter text. |
| **ROLE/DESIGNATION** | Click or tap here to enter text. |
| **CONTACT TEL / EXT** | Click or tap here to enter text. |
| **ADDRESS** | Click or tap here to enter text. |
| **DATE COMPLETED**  | Click or tap here to enter text. |
| **PLEASE CAN YOU PROVIDE US WITH AN UP TO DATE TIMETABLE / LESSON PLAN FOR SCHOOL OBSERVATION PURPOSES**  |

1. **What are the main difficulties (if any) as you see them?**

Click or tap here to enter text.

1. **In comparison with his/her peers how is the child at present in terms of:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Well Below Average | Below Average | Average | Above Average | Well Above Average |
| General level of ability |[ ] [ ] [ ] [ ] [ ]
| General level of attainment |[ ] [ ] [ ] [ ] [ ]
| Ability in reading |[ ] [ ] [ ] [ ] [ ]
| Ability in writingAbility in maths |[ ] [ ] [ ] [ ] [ ]
| Ability in spelling |[ ] [ ] [ ] [ ] [ ]

***Additional comments – Additional comments – (e.g. does the child’s chronological age differ significantly to their learning age?, are there any diagnosed or suspected learning disabilities?)*** Click or tap here to enter text.

**Is the child receiving any extra help and if so what strategies are in place?**

Click or tap here to enter text.

**Are any services already involved with the pupil? (Please provide name of worker if known)**

|  |  |
| --- | --- |
| SISS  | Click or tap here to enter text. |
| SEMH | Click or tap here to enter text. |
| Behaviour Support | Click or tap here to enter text. |
| Education Psychology (EPS) | Click or tap here to enter text. |
| Speech and Language Therapy | Click or tap here to enter text. |
| Communication and Autism Team (CAT) | Click or tap here to enter text. |
| Paediatrician | Click or tap here to enter text. |
| School Nurse | Click or tap here to enter text. |
| SAS | Click or tap here to enter text. |
| Other (please state) | Click or tap here to enter text. |

1. **Do any of the following apply to the pupil? (Please tick and add review date if appropriate)**

|  |  |
| --- | --- |
| Universal Provision[ ]  | Click or tap here to enter text. |
| Targeted Provision[ ]  | Click or tap here to enter text. |
| Specialist Provision[ ]  | Click or tap here to enter text. |
| Other (Please state)[ ]  | Click or tap here to enter text. |

*\*Please provide us with a copy of any recent paperwork related to the above where possible.*

1. **Compared with his/her peers, how would you rate the child in terms of the level of the following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Major Problem** | **Medium Problem** | **Minor Problem** | **No Problem** |
| Butting into others’ conversations |[ ] [ ] [ ] [ ]
| Leaving seat without permission |[ ] [ ] [ ] [ ]
| Difficulty turn taking |[ ] [ ] [ ] [ ]
| Forgetfulness |[ ] [ ] [ ] [ ]
| Inability to listen to instructions |[ ] [ ] [ ] [ ]
| Blurting answers out of turn |[ ] [ ] [ ] [ ]
| Fidgeting or squirming |[ ] [ ] [ ] [ ]
| Excessive and inappropriate running |[ ] [ ] [ ] [ ]
| Inability to complete task |[ ] [ ] [ ] [ ]
| Poor organisation |[ ] [ ] [ ] [ ]
| Careless errors in work |[ ] [ ] [ ] [ ]
| Excessively noisy in play |[ ] [ ] [ ] [ ]
| Excessive and inappropriate talking |[ ] [ ] [ ] [ ]
| Easily distracted |[ ] [ ] [ ] [ ]
| Inability to sustain attention |[ ] [ ] [ ] [ ]
| Dislike of tasks requiring concentration |[ ] [ ] [ ] [ ]
| Losing things necessary for certain tasks eg books |[ ] [ ] [ ] [ ]
| Excessive motor activity |[ ] [ ] [ ] [ ]

1. **How would you rate the following?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Well below average** | **Below average** | **Average** | **Above average** | **Well above average** |
| Self esteem/confidence |[ ] [ ] [ ] [ ] [ ]
| Response to rules & discipline |[ ] [ ] [ ] [ ] [ ]
| Attendance record(in %) |[ ] [ ] [ ] [ ] [ ]

1. **Personality – Please tick the adjectives which you think best apply to this child:**

happy [ ]  content [ ]  likeable [ ]  lively [ ]  noisy [ ]  self-confident[ ]  adaptable [ ] quiet[ ]  shy [ ]  sad[ ]  popular [ ]  caring [ ]  anxious [ ]  fearful [ ]  sensitive[ ]  immature [ ]  fussy [ ]  attention-seeking [ ]  withdrawn [ ]  aggressive [ ]  mature [ ]  compliant[ ]  disobedient [ ]  hyperactive[ ]  tidy [ ]  careless [ ]  perfectionist[ ]

***In addition, please tell us how you would describe the child’s personality:***

Click or tap here to enter text.

1. **Relationship with Peers – Please comment on how the child relates to other children ie, ability to work and play cooperatively, ability to make and maintain friendships, problems with bullying.**

Click or tap here to enter text.

1. **Relationship with Adults – Please comment on how the child relates to adults, ie
cooperativeness, seeking help, response to discipline and encouragement.**

Click or tap here to enter text.

1. **General behaviour – Structured (lesson) time.**

Click or tap here to enter text.

1. **General behaviour – Unstructured (Break) time.**

Click or tap here to enter text.

1. **Additional comments/concerns: In your opinion, how does this child’s general behaviour and emotional development compare with the normal range for his/her age?**

Click or tap here to enter text.

PLEASE CAN PARENTS/CARERS AND CORE SUBJECT TEACHERS FILL OUT THE ATTACHED SNAP-IV 26 FORM AND RECORD OUTCOMES BELOW –

Please use the hyperlink or QR code below to do so.

[SNAP-IV 26 - Teacher & Parent Rating Scale | QxMD](https://qxmd.com/calculate/calculator_147/snap-iv-26-teacher-parent-rating-scale)

*Once you have completed the questionnaire please copy and paste your answers onto the end of this document. Please make sure to clearly identify who has filled out the questionnaire.*

Name: Click or tap here to enter text. Relationship to child: Click or tap here to enter text.

Click or tap here to enter text.

Name: Click or tap here to enter text. Relationship to child: Click or tap here to enter text.

Click or tap here to enter text.

Name: Click or tap here to enter text. Relationship to child: Click or tap here to enter text.

Click or tap here to enter text.

Name: Click or tap here to enter text. Relationship to child: Click or tap here to enter text.

Click or tap here to enter text.