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| **0-19 School Nurse Referral Form for Concerns Regarding:** **Behaviour, Social Communication, and/or Dyspraxia****For School Age Children Only (F2 to Year 13)**Please give as much detail as possible when filling out each section to aid with triage.This form **MUST** be signed by parent/carer and SENCO/referring professional Paediatricians have requested referrals to be submitted in a typed, electronic format Questions with a Black heading are to be completed by parent/carerQuestions with a Grey heading are to be completed by SENCO/referring professional.**All areas marked with (\*) MUST be completed or the referral will be declined.**  |
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| **\*Please select the reason this child is being referred** *- SENCO/Referrer to Complete**Multiple reasons can be ticked. For each tick you MUST complete the relevant section.* |
|

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| --- | --- | --- |
|  | Please tick |  |
| **Behavioural Concerns** | [ ]  | You must complete: | Section **A** | & | Section **B** |
| **Social Communication Concerns** | [ ]  | You must complete: | Section **A** | & | Section **C** |
| **Dyspraxia Concerns** | [ ]  | You must complete: | Section **A** | & | Section **D** |

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| **SECTION A** This entire section must be completed for any referral. |
|  |
| **\*Child’s Current School / Setting (if applicable):** *- SENCO/Referrer to Complete* |
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| --- | --- |
| Name of setting: | Class teacher: |
| \*SENCO: | \*Tel No: |

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| **\*Child Details:** *- SENCO/Referrer or Parent/Carer to Complete* |
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|  |  |
| --- | --- |
| \*Surname: | \*Address: |
| \*Forename: |
| \*DOB: |
| First Language: |
| \*Sex at Birth: | \*Postcode: |
| \*Gender: |  |
| Ethnicity: | \*Requires Interpreter/Translation: [ ]  (If ticked, please note language below) |
| Religion: |  |
| \*Looked after child [ ]  | \*Tel No: |

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|  |
| **\*Parent(s) / Carer(s) Details:** *- SENCO/Referrer or Parent/Carer to Complete* |
|

|  |  |
| --- | --- |
| \*Surname: | Surname: |
| \*Forename: | Forename: |
| Address: | Address: |
| Postcode: | Postcode: |
| \*Tel No: | Tel No: |
| \*Relationship: | Relationship: |

 |
| **\*Child’s Status (if applicable)** *- SENCO/Referrer or Parent/Carer to Complete* |
| **Is the child subject to any of the following statuses?**SECTION **A***If so, please tick and enter relevant information if known*

|  |  |  |
| --- | --- | --- |
|  | Lead professional name | Contact details |
| [ ]  | TAF |  |  |
| [ ]  | CIN |  |  |
| [ ]  | CPP |  |  |
| [ ]  | CLA |  |  |

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| **\*Referrer Details -** *SENCO/Referrer to Complete* |
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|  |  |
| --- | --- |
| \*Name: | \*Date: |
| \*Designation: | Address: |
| \*Signed:  |

**All sections of this form must be completed. If all details are not completed the form will be returned to the referrer**. **All referrals must be sent electronically to:** wcnt.neurodevelopmentalreferrals@nhs.net |

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| **Medical History** *- Parent/Carer to Complete**Please fill in all the sections below. (If not applicable, write N/A)* |
| SECTION **A**

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| **Were there any complications** **during the child’s birth you feel we should know about?:***(e.g. Premature delivery, emergency caesarean)* |
|

|  |  |
| --- | --- |
| Yes | [ ]  |
| No | [ ]  |
| Unknown | [ ]  |
| Prefer Not to Say | [ ]  |

*If you wish to include further detail, please comment here* |
| **\*Did you have any concerns about any developmental milestones?:***(e.g. Walking or talking delayed)* |
|

|  |  |
| --- | --- |
| Yes | [ ]  |
| No | [ ]  |

*If yes, please comment here* |
| **\*Does the child have any hearing issues?:***(e.g. Used a hearing aid)* |
|

|  |  |
| --- | --- |
| Yes | [ ]  |
| No | [ ]  |

*If yes, please comment here* |
| **Does this child have any medical conditions you are aware of?** *(e.g. diabetes, epilepsy, meningitis or had any accidents such as a head injury)* |
|

|  |  |
| --- | --- |
| Yes | [ ]  |
| No | [ ]  |
| Prefer Not to Say | [ ]  |

*If you wish to include further detail, please comment here* |
| **\*Does this child take any prescribed medication regularly?:***(e.g. Inhalers, insulin)* |
|

|  |  |
| --- | --- |
| Yes | [ ]  |
| No | [ ]  |

*If yes, please comment here* |

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| **\*Family History:** *Parent/Carer to Complete**Please fill in all the sections below. (If not applicable, write N/A)*  |
| SECTION **A**

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| **\*Who does child currently live with?:***(e.g. Parents, carers, siblings, joint custody arrangements)* |
|  |
| **\*Is there any confirmed diagnosis of neurodevelopmental conditions in the family?** *(e.g. ADHD, Autism, Dyslexia)* |
| Yes [ ]  No [ ]  *If yes, list family member and condition discussed and whether condition is medically diagnosed and medicated.* |
| **\*Has your child ever been assessed for a Neurodevelopmental condition in a previous area or country outside of Wirral?***(e.g. ADHD, Autism, Dyslexia)* |
| Yes [ ]  No [ ]  *If yes, please give further details below* |
| **\*Does this child have any siblings currently under a Paediatrician?:**  |
| Yes [ ]  No [ ]  *If ‘Yes’ please fill in below:*

|  |  |
| --- | --- |
| **Name of sibling:** |  |
| **Date of Birth** |  |
| **Name of current Paediatrician:** |  |
| **Do you with this child to also be under the care of this paediatrician if possible?** | Yes [ ]   | No [ ]   |

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| **\*Parent/Carer Consent to Refer -** *Parent/Carer to Complete**This section must be completed* |
|

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **I agree for this child to be referred for the condition as indicated on the 1st page of this referral.****I understand that for this referral to progress, information within this referral will need to be shared with Community Paediatricians at Wirral University Teaching Hospital and potentially The ADHD Foundation, 0-19 Children’s Speech & Language Therapy, CAMHS, or other relevant services depending upon the referral.****I understand that appointment for assessments may be required. I agree to be contacted by the 0-19 service to arrange appointments and to update the 0-19 service if my address or contact details change during this referral.****If these appointments are not attended, this child’s referral will not proceed and they will be discharged.**Wirral Community Trust Privacy Statement:[*https://staff.wirralct.nhs.uk/index.php/privacy-statement*](https://staff.wirralct.nhs.uk/index.php/privacy-statement)

|  |  |
| --- | --- |
| \*Parent/Guardian Name: |  |
| \*Date:  | \*Signature: |

***Written consent is required from parent/carer.******If this is not possible, clear notification that verbal consent was gained must be clearly recorded below.******If a written consent is obtained, verbal consent is not required***

|  |  |  |
| --- | --- | --- |
| Verbal Consent Gained | Yes | [ ]  |

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