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