|  |
| --- |
| **Child’s Details** |
| **Child’s Name** |  | **Date of Birth** |  |
| **Gender** |  | **NHS Number** **(Mandatory)** |  |
| **Address** |  |
| **Name of Parents/Carers** |  |
| **Contact Number** |  |
| **Interpreter Needed** | **Yes** [ ]  **No** [ ]  | **Language** |  |
| **GP Practice**  |  |
| **School/Nursery** |  |
| **Reason For Referral** [***SEE EXCLUSION CRITERIA (PAGE 3)***](#Page4) |
| **Supporting evidence is required alongside the referral for certain conditions as stated below. Failure to provide this may delay processing of the referral or result in return of the referral for further information.****Note: Education Services to only refer for Social Communication concerns.**  |
| ***PLEASE TICK BOX(ES) AND COMPLETE RELEVANT APPENDICES*** |
| **Developmental Delay in Pre-School Children**[*Complete form- Appendix 1 (pages 4-5) – please click here*](#Appendix1) |[ ]
| **Social, Communication and Interaction Difficulties (age 2 to 6 years 11 months)\*****(Can be referred by Education)**\*Under 2 years - suggest universal services/hearing test/nursery input for three months initially[*Complete forms- Appendix 2A and 2B (pages 6-11) – please click here*](#Appendix2A) |[ ]
| **Significant Learning Difficulties**(If medical cause suspected)[*Complete form- Appendix 3 (pages 12-13) – please click here*](#Appendix3) |[ ]
| **Coordination/Motor Difficulties**[*Complete form- Appendix 4 (pages 14-17) – please click here*](#Appendix4) |[ ]
| **Known or suspected syndrome/Chronic Neurodisability** |[ ]
| **Developmental Regression** |[ ]
| **Neuromuscular problem** |[ ]
| **Severe Visual Impairment** |[ ]
| **Permanent Hearing Impairment** |[ ]
| **Other** *(Complete Details of Referral on Page 2)*  |[ ]
| **Details of Referral** |
| *If necessary, please attach/upload continuation sheet or referral letter. Some referrals require Additional Information- see Appendices* |
|  |
| **Background Information** |
| **Safeguarding Concerns: Yes** [ ]  **No** [ ]  | **Is the Child Looked After:: Yes** [ ]  **No** [ ]  |
| **If yes, details:**  |
|  |
| **Are any other family members attending the Child Development Service? Yes** [ ]  **No** [ ] **If Yes:**  |
| **Name of family member** |  | **Date of Birth:**   |
| **Which Consultant are they seeing?** |  |
| **Referral Details** |
| **Referrer’s Name** |  | **Role/Designation** |  |
| **Address** |  | **Contact Number** |  |
| **Signature** |  | **Date** |  |
| **Parental consent for referral and sharing of the SystmOne Record*****(MANDATORY)*** | **Yes** [ ]  **No** [ ]  |
| **Parental consent for the Child Development Service to request and share information with other services involved with their child’s care.** ***For example, school/nursery, Bradford Education Services, Educational psychology, Physio/Occupational Therapy/CAMHS etc.*** | **Yes** [ ]  **No** [ ]  |
| **Copy of this referral form sent to GP** ***(MANDATORY unless submitted via SystmOne)***  | ***Please Tick:-*** [ ]  |
|  |  |
| **How Do I Make A Referral?** |
| Please send the completed form **and** relevant appendices electronically via:* SystmOne
* Or secure email to Bradfordchilddevelopment.referrals@nhs.net
* Or by Post to: Child Development Service Referrals Team, Top Floor, Extension Block, St Luke’s Hospital, Little Horton Lane, Bradford, BD5 0NA
* For queries  01274 365814
 |

|  |  |
| --- | --- |
| **EXCLUSION CRITERIA****Inappropriate referrals***List not exhaustive*  | **Signposting to appropriate services** |
| *Child does not have a Bradford GP* | Referrer to redirect to correct geographical service |
| *Social, Communication and Interaction Difficulties – 7 years of age and over**(The CDS do not do autism assessments for children 7 years of age and over)* | *Refer to CAMHS* |
| *ADHD* | *Refer to CAMHS* |
| *Behaviour difficulties in an otherwise normally developing child*  | *Health Visitor/School Nurse (who can refer to CAMHS if appropriate)* |
| *Behaviour difficulties associated with a neurodevelopmental condition, if child previously known to the service* | *Discuss with CDS clinician before considering referral*  |
| *Sleep difficulties*  | *Health Visitor/School Nurse* |
| *Sleep difficulties associated with a neurodevelopmental condition, if child previously known to the service* | *Discuss with CDS clinician before considering referral* |
| *Dyslexia* | *SENDCO (special educational needs coordinator) in school* |
| *Long-term Enuresis* | *School Nurse initially. May need GP assessment and/or Paediatric Continence Service Referral* |
| *Constipation and Soiling* | *GP and/or referral to General Paediatrics or Specialist Paediatric Continence Nurse via Choose and Book.*  |
| *Weight Loss/Growth Failure/Obesity* | *GP and/or referral to General Paediatrics via Choose and Book.* |
| *Medical Problems such as abdominal pain/headaches/constipation* | *GP and/or referral to General Paediatrics via Choose and Book.* |
| *Suspected epileptic seizures with no underlying developmental concerns* | *Referral to General Paediatrics via Choose and Book* |
| *Abnormal Head Size* | *Referral to General Paediatrics via Choose and Book* |

**Appendix 1**

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| --- |
| **Referral for Pre-School Developmental Delay*****Reason for referral due to developmental delay (not primarily autism-related). For referrals for possible autism, please see separate form*** |
| Child’s Name:  | Date of Birth:  |
| **Is there any reason for this child to have delayed development?** *Please include any known diagnosis, significant birth and neonatal details and current regular medication. You can also include here any particular social circumstance that may contribute to developmental delay and whether there was any history of exposure to drugs (pharmaceutical or recreational) during pregnancy.* |
|  |
| **Locomotor skills**Is the child able to sit unsupported? Crawl? Walk (and if so does this require assistance), get up and down stairs? Run? Hop? |
|  |
| **Hand Skills***Does the child use their eyes to follow faces? Do they grasp a block? Do they mouth objects? Are objects transferred between hands/clapping? Is there evidence of pincer grip? Do they point with index finger? Can they build a tower with blocks? Do they attempt drawings? Any evidence of early hand preference (<18 months)?*  |
|  |
| Have you requested Portage involvement?  |
| **Hearing and Speech***Are there any concerns with hearing? Does the child turn to parent’s voice? Do they respond to their name? Have they developed any words yet- if so, how many? Is the child feeding appropriately? Any evidence of choking on feed?* |
|  |
| Have you considered referral for hearing test. If so when has this happened?  |
| If concerns with swallowing or child >2 years with poor speech have you referred to Speech and language therapy?  |
| **Social, emotional, behavioural***Any evidence of social smile? Do they laugh in play? Do they show excitement in game such as peek- a- boo? Will they wave goodbye? Do they follow a fallen object? Can they use a spoon or fork? Do they get involved in symbolic play?* |
|  |
| Please use this space to include any other details that you may feel are relevant to the referral, but have not been covered under the above headings.  |
|  |

**Appendix 2A**

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| **Autism /Social Communication Referral -** **Supporting Information from Referrer and Parents** **Please also include a Nursery or School report (see Appendix 2B)** **Please ensure you have parental consent for sharing this information** |
| Child’s Name:  | Date of birth:  |
| Nursery/ School:  | Year Group: |

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| **General Development and Health** - Cognition and learning, Gross motor milestones, Fine motor skills, Self-care skills: toilet, feeding, dressing, etc, Vision, Hearing (hearing test?), Sleep, Feeding, Growth, any underlying medical condition |
|  |
| **Communication** - *How does the child communicate? Speech and Language development (Speech and Language Therapy referral?) Response to being talked to* |
|  |
| **Social Interaction and Relationships -** *with adults, with other children/ groups* |
|  |
| **Play -** favourite activities, pretend play |
|  |
| **Behaviour -** routines, repetitive behavior, stereotyped repetitive body movements, challenging or negative |
|  |
| **Sensory Behaviours –** e.g. reactions to noises, smells, textures, unusual visual interests |
|  |
| **Any other concerns or information you feel would be helpful for the assessment-** *family history, etc* |
|  |
| **Other Professionals Involved** |
|  |
| **Form completed by** |  |  |
| **Role** |  |  |
| **Signature** |  |  |
| **Date** |  |  |

**Appendix 2B**

|  |
| --- |
| **Autism/ Social Communication Referral -** **Supporting Information from School/Nursery** |
| Child’s Name:  | Date of birth:  |
| Nursery/ School:  | Year Group:  |
| Name of person completing form:  | Date completed:  |

|  |
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| **Progress with learning –** *What progress is the child making on the Early Years Foundation Stage, any additional support in the setting, how have they progressed since starting in the setting.* ***Please send a copy of the child’s IEP and Developmental Profile if they have one.***  |
|  |
| **Speech and Language –** *How is the child’s language i.e. is the child verbal/non-verbal,* *does the child’s speech seem unusual i.e.**repetition, babbling, pitch, tone, rhythm, stereotyped phrases.*  |
|  |
| **Social Interaction –** *Eye contact, facial expressions, gestures, body posture, sharing enjoyment, social emotional reciprocity,*  |
|  |
| **Relationships with others (peers and staff) –** *appropriate and meaningful interaction, developing and maintaining relationships, physical contact, how does the child interact with others? Do they respond or initiate contact? Do they shown concern for others or seek comfort?*  |
|  |
| **Play, Imagination and Progress –** *Does the child play imaginatively, do they play cooperatively with other children or prefer to play alone? Do they take turns, what games do they play?*  |
|  |

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| **Sensory Behaviours** *- sensory interests or responses i.e. mouthing objects, repetitively touching objects, aversion to loud noises or bright lights etc* |
|  |
| **Any unusual/challenging behaviours –** *Repetitive behaviours, aggressive behaviours, routines, obsessions, unusual body mannerisms i.e. hand flapping, body rocking etc.* |
|  |
| **Any other concerns or information you feel would be helpful for the assessment** |
|  |

**Appendix 3**

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| **Education Report** **Referral for Learning Difficulties to assess if there is a medical cause.** **Please note that the CDS does not do assessments for formal Learning Disability diagnosis.** |
| **Child’s Name** |  | **Date of Birth** |  |
| **School** |  | **Year Group** |  |
| **Concerns from School** |
| **Please include the following if relevant:-** |
| * *Progress with learning*
* *Difficulties affecting participation in school/barriers to learning*
 | *- speech and communication**- mobility/self-care skills**- behaviour/social interaction*  |
|  |
| **Current Learning Levels** |
| *Please be clear on how far behind the child is compared to their year group* |
| **Subject** | **Current Level** | **Expected Level for a child of this age** |
| Reading |  |  |
| Writing |  |  |
| Speaking/Listening |  |  |
| Maths  |  |  |
| Science |  |  |
| Personal, Social and Emotional Development |  |  |
| Self-Care Skills |  |  |
| **Attendance (%)** |  |
| **Description of additional support the child has in school** |
| *What support does the child/young person require in school?*  |
| **Does the child have an EHCP?**  | Yes [ ]  No [ ]  |
| **Other Professionals Involved (circle)** | Educational Psychology | Yes [ ]  No [ ]  |
| Speech and Language Therapy | Yes [ ]  No [ ]  |
| Learning Support Services | Yes [ ]  No [ ]  |
| Other:- |

|  |
| --- |
| **Please include copies of any IEP, SCERTS, Learning Support Assessments or Educational Psychology reports (if available).** |
| **Form completed by** |  |
| **Role** |  |
| **Signature** |  |
| **Date** |  |
| **Please ensure you have parental consent for sharing this information and then return this completed form to the person making the referral e.g. school nurse, GP.**  |

**Appendix 4**

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| **For Referral For Motor Coordination Difficulties*****The child is likely to need assessment by Physiotherapy and/or Occupational Therapy before the child is seen by the Paediatrician. The referral to Therapy team can be done by the Paediatrician but ONLY IF parents/ carers provide verbal consent.*** |
| Child’s Name:  | Date of birth:  |
| **Please provide the following information (mandatory)** |
| **Consent given by parent for referral to Physiotherapy and/or Occupational Therapy** **Yes** [ ]  **No** [ ] **And complete the questionnaires below (parental questionnaire and school questionnaire**  |
| **Parent Questionnaire for Motor Coordination Difficulties** |
| **Play and Leisure***Please indicate if the child has difficulties in any of the following* |
|  | **Sometimes** | **Most of the Time** |
| Throwing a ball in a controlled way |[ ] [ ]
| Catching a tennis ball from 6-8 feet |[ ] [ ]
| Jumping over obstacles in path |[ ] [ ]
| Running at similar speed to peers |[ ] [ ]
| Riding a bicycle without stabilizers |[ ] [ ]
| Cutting shapes accurately |[ ] [ ]
| **Please provide details or any additional information here** |
|  |
| **Self-Care Skills***Does your child need adult support/help for* |
|  | **Sometimes** | **Most of the Time** |
| Dressing/undressing |[ ] [ ]
| Using knife and fork |[ ] [ ]
| Doing zips and buttons |[ ] [ ]
| Accessing the toilet independently |[ ] [ ]
| **Please provide details or any additional information here** |
|  |
| **Learning** |
| Any reading difficulties | **Yes** [ ]  **No** [ ]   |
| Is your child able to write with similar speed to children of his/her age | **Yes** [ ]  **No** [ ]   |
| Is your child able to produce legible writing | **Yes** [ ]  **No** [ ]   |
| **Please provide details or any additional information here** |
|  |
| **Behaviour and interaction** |
| Does your child have problems with self-confidence | **Yes** [ ]  **No** [ ]  **Sometimes** [ ]  |
| Does your child avoid physical activities | **Yes** [ ]  **No** [ ]   |
| **If ‘Yes’ please provide details** |
|  |
| **Any concerns about hearing or vision? If yes, please get hearing/vision checked** |
|  |

**Please complete the questionnaire below (school questionnaire)**

|  |
| --- |
| **School Questionnaire for Motor Coordination Difficulties** |
| **Name of child:** |  |
| **School:**  |  |
| **Year Group:** |  |
| **Report completed by:** |  |
| **Does the child have EHCP? Yes** [ ]  **No** [ ]  |
| **Has the child been assessed by Educational Psychologist/Specialist teacher?** **Yes** [ ]  **No** [ ]  *If Yes, please attach report* |
| **Learning levels** |
|  | Above age related expectations | At age related expectations | Below age related expectations |
| Maths |[ ] [ ] [ ]
| Reading  |[ ] [ ] [ ]
| Writing |[ ] [ ] [ ]
| **Please give an overview of progress being made in learning and support provided** |
|  |
| **Please indicate if the child has difficulties in any of the following and provide details of the difficulties** |
|  | **Sometimes** | **Most of the time**  |
| Producing legible handwriting |[ ] [ ]
| Pencil grip |[ ] [ ]
| Writing speed |[ ] [ ]
| Letter formation and spacing |[ ] [ ]
| Completing task within expected time period |[ ] [ ]
| Cutting with scissors |[ ] [ ]
| Dressing |[ ] [ ]
| Using knife and fork |[ ] [ ]
| Accessing toilet independently |[ ] [ ]
| Difficulty in organizing their desk/study area |[ ] [ ]
| Avoiding obstacles when running |[ ] [ ]
| Hopping |[ ] [ ]
| Jumping |[ ] [ ]
| Participating in PE |[ ] [ ]
| Throwing a ball in controlled fashion |[ ] [ ]
| Catching a tennis ball from 6-8 feet distance |[ ] [ ]
| **Please provide details about the difficulties as well as the support provided** |
|  |
| **Does the child have difficulties in** |
| Difficulty in forming friendships | **Yes** [ ]  **No** [ ]   |
| Low self esteem  | **Yes** [ ]  **No** [ ]   |
| **If ‘Yes’ please provide details** |
|  |