Part A

Lancashire Teaching Hospitals NHS Foundation Trust Community neurodevelopmental paediatrics referral form – Professionals

|  |
| --- |
| If this referral is relating to possible ADHD please provide evidence that parents or carers have been referred and attended a group-based ADHD-focused support as per NICE guidelines for Attention deficit hyperactivity disorder: diagnosis and management clause 1.2.7. |
| **Name of Course** | **Date Attended** |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Child/Young Person’s Details** |
| Name of Child/Young Person |  |
| Date form Completed |  | Date of Birth |  | NHSNumber (If know) |  |
| Home address (incpostcode) |  | MobileNumber |  |
| Gender |  | EthnicGroup |  |
| Spoken Language |  | Interpreterrequired | Yes ☐ No☐ |
| Name of GP |  | Address ofGP |  |
| Nursery/school/college |  | Emailaddress |  |

|  |
| --- |
| **Child/Young Person’s Main Carers (if under 18 years old)** |
| **Name** | **Relationship to child/Young****Person** | **Parental Responsibility** |
|  |  | Yes ☐ No ☐ |
|  |  | Yes ☐ No ☐ |

|  |  |  |
| --- | --- | --- |
|  |  | Yes ☐ No ☐ |
|  |  | Yes ☐ No ☐ |

****

|  |
| --- |
| **Referrer Details** |
| Name of referrer |  |
| Designation of referrer |  |
| Address |  |
| Email |  | Telephone Number |  |
| Signature ofreferrer |  | Date |  |

|  |
| --- |
| **Safeguarding the child/Young person** |
|  | **CAF** | **Child in Need** | **Child Protection Plan** | **Looked after Child** | **Adopted or special guardianship****order** |
| **Tick if in place for the child/young person** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Tick if in place for any other member of****the family** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Please provide details where****appropriate** |  |

|  |
| --- |
| **Other professionals involved with the Child/Young Person** |
|  | **Tick if****involved** | **Name and contact information** |
| Health Visitor or School Nurse | ☐ |  |
| Speech and Language Therapist | ☐ |  |
| Portage | ☐ |  |

|  |  |  |
| --- | --- | --- |
| Nursery, School, College orWorkplace support | ☐ |  |
| Social Worker | ☐ |  |
| Specialist (Inclusion) Teacher | ☐ |  |
| Educational Psychologist | ☐ |  |
| Learning Disability Team | ☐ |  |
| Child and Adolescent Mental Health (CAMHS)/Child Psychology Integrated Service | ☐ |  |
| Community (Neurodevelopmental)Paediatrician | ☐ |  |
| Hospital Consultant | ☐ |  |
| Youth Offending Team | ☐ |  |
| Other service(s) | ☐ |  |

****

|  |
| --- |
| **Has the young person, or parent if under 16, consented to this referral?** |
| Yes ☐ | No ☐ |
| **Has the young person, or parent if under 16, been given Part B to complete and****return?** |
| Yes ☐ | No ☐ |

|  |
| --- |
| **What are your main concerns about this child / young person?** |
|  |
| **Please describe current concerns about the child/young person in relation to their:** |
| **Social communication** (use of language for range of functions / maintenance of conversation /awareness of listener / vocabulary development / voice control, tone, volume, rate, expression / response to interaction / understanding of complex and non-literal language /understanding of gesture, tone and facial expression) |
|  |
| **Language skills** (level of understanding, speech clarity, selective mutism, stammer or stutter) |

|  |
| --- |
|  |
| **Social interaction** (awareness of others / interest in people / seeking comfort/empathy skills /awareness of feelings and emotions / building friendship / turn taking / eye contact / gesture / inappropriate behaviour). |
|  |
| **Flexibility of thought** (pretend play / imagination / need for routine / resistance to change /repetitive or stereotyped behaviour / obsessions or movements / all consuming interests) |
|  |
| **Sensory behaviours** (preferences for food, smell, clothing, noises etc.) |
|  |
| **Attention / concentration** (attention and concentration / focus on task / forgetfulness/ day dreaming / organisational skills) |
| **If you have concerns with attention/concentration please see appendix A** |
| **Hyperactivity & impulsive behaviours** (excessive energy, fidgeting, frequent body movements / excessive talking / impatience / lack of sense of danger) |
| **If you have concerns with hyperactivity and impulsive behaviours please see appendix A** |
| **Physical health** (diagnosed conditions, treatment, hospital admissions, sleep difficulties, toileting issues) |
|  |

|  |
| --- |
|  |
| **Learning and development: Please give information on how the child is learning, how they compare to peers, meeting targets and any extra interventions that are required** |
|  |
| **Classroom Assistant:** |
| * Part Time
 |
| * Full Time
 |
| * No
 |
| Do they have an EHCP? | Yes☐ | No☐ |
| **What additional support is in place?** |
| **Do they receive outreach support?** | **Yes**☐ | **No**☐ |
| **If yes, from:** |
| **Have they been referred to an educational psychologist?** | **Yes**☐ | **No**☐ |
| **If yes, date of referral:** |
| **Are they known to an educational psychologist already? (If yes, please attach a copy of the report)****(In the presence of severe learning difficulties and non-verbal ASD, these referrals should be direct to CAMHS)** | **Yes**☐ | **No**☐ |
| **Is One plan or Early Support Plan in place? (*if yes, please attach a copy of the plan. If not please attach a report that details relevant support in place)*** | **Yes**☐ | **No**☐ |
| **Family circumstances****PLEASE STATE IF THERE ARE ANY SAFEGUARDING ISSUES** |
|  |  | Comments |
| Physical Abuse | Yes ☐ No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Sexual abuse | Yes | * No
 |  |
| Emotional abuse | Yes | * No
 |  |
| Living with someone who used drugs/unlawful substances | Yes | * No
 |  |
| Living with someone who abused alcohol | Yes | * No
 |  |
| Expose to domestic violence | Yes | * No
 |  |
| Living with someone with serious mental illness | Yes | * No
 |  |
| Losing a parent through | Yes | * No
 |  |
| divorce, death orabandonment or prison |  |  |
| sentence |  |  |
| Neglect | Yes | * No
 |  |
| **What has been put in place or tried to support the child’s emotional wellbeing? How effective was it?** |
|  |

****

**Completed by: Designation:**

**Date:**

**\*Continued on next page\***

|  |
| --- |
| **Please attach any appropriate reports / assessments about the child/ young person. The more information you can provide, the more efficient the assessment****process. Examples of documents and reports that you may want to include are listed below** |
|  | **Available** | **Attached** |
| CAF (Common Assessment Framework) |  |  |
| GP Report (Birth and early development) |  |  |
| School Nurse or Health Visitor Report |  |  |
| Portage Report |  |  |
| Nursery/school/college report |  |  |
| Educational psychologist report |  |  |
| Educational Health Care Plan (EHCP) |  |  |
| CAMHS or Clinical Psychology report |  |  |
| Community(Neurodevelopmental) PaediatricianAssessment |  |  |
| Speech and Language Therapist Report |  |  |
| Occupational Therapist Report |  |  |
| **Return of Form** |
| Ensure all relevant reports and screening tools are attached and returned to: |
| Please note that referrals can only be processed once both Part A and Part B have been received. Failure to follow the above instructions will result in delays in processing.Thank you. |

**APPENDIX A**

ADHD Referral Guidance (ADHD NICE guidance NG87)

* For the referral to be screened by the team, please ensure you have attached any relevant documentation/evidence including: SNAP IV forms, School assessment forms (including learning levels), relevant social care assessments, Paediatric Clinic letters and EHCPs. **Referrals that do not contain the necessary information will be returned to source.**
* Referrals can be made by a lead professional; this will be the

professional who knows the family best, has regular contact with the family and is able to collate the supporting evidence above. This may be a School Nurse, Health visitor, SENCO, Social Worker etc. Please ensure consent is gained from the family, in certain cases the young person, for the service to discuss and share information as we work in partnership with other agencies.

* Referrals will need to be in collaboration with the Child or Young Person’s school including teachers or Special Educational Needs Coordinators as evidence of the graduated approach is required.
* Referrals must include a completed home and school SNAP-IV form. If you do not have a copy of this form this can be requested from the above email address. Failure to provide these documents will result in the referral being returned