Child Health Service referral form

Physiotherapy

*Required field

For referrals to be accepted the following is required	
Please use this referral form for children who are presenting with difficulties only in delayed gross motor skills. Those children presenting with delays in more than one area e.g. gross motor skills and speech and language skills should be referred to the violet pathway where they can receive a multi-disciplinary approach. Core standards – Please ensure children have had maximum opportunity to improve their skills prior to referral.	☐

General information

*Date of referral		*Childs date of birth	
*Childs first name		*Childs family or last name	
*Name child likes to be known by		NHS Number (if known)	
*Name of parent/carer/guardian with parental responsibility			
*Email of parent/carer for appointments, reports and information to be sent			
*Address where the child lives			
*Contact number for parent /carer			
Name of second parent that has legal responsibility (if different from above)			
What is the relationship to parent listed above			
Email of second parent/carer for appointments, reports and information to be sent			
Address of second parent/carer if different to listed above			
Contact number of second parent/carer			

Who else works with the family or child?

*GPs name and address	
Hospital doctors name and address	

Service		Service	
☐	Speech and language therapy	☐	Physiotherapy
☐	Occupational therapy	☐	Dieticians
☐	Podiatry	☐	Learning disability nurses
☐	Social worker	☐	Community nurses
☐	Health Visitor	☐	School nurse
☐	Child and adolescent wellbeing service (NELFT)	☐	Special needs nursery
☐	Audiology	☐	Ophthalmologist
Other – please state:			

For schools and nurseries

*Name and address of nursery or school	
*Contact person name and email address	
*Contact number	

Safeguarding

	Yes	No
*Does the child have a child protection plan?	☐	☐
*Is the child a child in need?	☐	☐
*Is the child a looked after child?	☐	☐
*Has early help been initiated?	☐	☐

Any further information	
Social workers name and contact details	

Consent

	Yes	No
*Are the parents/carers in agreement to this referral?	☐	☐

*Referrers name and address	
*Email address	

Pathway specific questions

1. Does the child have a known diagnosis? If yes please provide information	
2. What are the main concerns/reasons for referral?	
3. How long have these concerns been present?	
4. How are these concerns impacting on the child?	
5. Does the child have pain?	
6. Is there any significant information regarding birth history or has the child had a trauma? e.g. type of delivery (vaginal, caesarean, forceps etc) and term of baby	
7. Developmental milestones - please indicate the age the child became independent in the following;	

Rolling		Use a spoon/fork	

Sitting alone		Drink from an open cup	
Crawling		Dress self	
Pull to stand		Toilet trained	
Stand unaided		Mark make	
Walking			