Swale Children's Therapy Team – Referral form

NB: All referral are triaged and children will be seen by the most appropriate professional – this may not be the person you have requested initially.

Child's name:		Date of birth:	
Address:		NHS number:	
Home phone number:		Mobile number:	
Ethnicity:			
Language(s) spoken at home:			
Interpreter required?	Yes ☐	No ☐	
State which language:			
Name of parents/carer/guardian (with parental responsibility):			
Do you currently buy in our traded services (MCH+)?	Yes ☐	No ☐	
If yes, and the referral is not accepted under NHS criteria, do you want the child to be seen under your traded contract?	Yes ☐	No ☐	

Nursery/school:			
Nursery/school address:			
Nursery/school contact person:			
Nursery/school telephone number:			
Does the child have an EHCP?	Yes ☐	No ☐	
How would you describe the child's learning abilities?			

GP name and address:	
Consultants:	
Health visitor/school nurse:	
Medical history/diagnosis:	

Safeguarding information

Child protection plan:	Yes ☐	No ☐
Child in need:	Yes ☐	No ☐
Known to Social Services disabilities team:	Yes ☐	No ☐
Looked After Child:	Yes ☐	No ☐
Any further information:		
Named Social Worker:		
Contact details:		

Visual impairment:	Yes ☐	No ☐	Hearing impairment:	Yes ☐	No ☐
Other services involved:					

Feeding and swallowing

Do you have any feeding or swallowing concerns?	Yes ☐		No ☐	
If yes, please complete:	Weight:		Height:	
Date last weight / height taken:				
Age when weaned:		Current feeding method:		
How long does it take for your child to eat a meal?				
Have they had any chest infections?	Yes ☐		No ☐	
If yes, how many in the last 6 month?				

Additional relevant questionnaires/reports/assessments must be attached for the referral to be accepted.

What interventions have been tried and outcome?

Intervention	Outcome

Has Early Help been initiated?	Yes ☐	No ☐
If yes, please include minutes:		

Reason for referral (How does this affect their daily lives?)

1	
2	
3	
4	

Are parents in agreement with this referral (if no, we will be unable to proceed with the refer)	Yes ☐	No ☐
Date of referral:		
Referrer name:		
Contact details:		
Telephone number:		