

**Child Health Service referral form**

**Complex Health Needs**

**(Violet Pathway)**

\*Required field

|  |
| --- |
| **For referrals to be accepted the following is required**  |
| Children up to and including 19 years of age (if in specialist provision) should be referred to the child health service.  Young people over the age of 19 years should be referred to adult services. Core standards/Universal services – Please ensure children have had maximum opportunity to improve their skills prior to referral. For assessment of ASD/ADHD please refer to Indigo Pathway. For children presenting with delay or disorder in only one area please refer to the yellow pathway.  **Please use this referral form for:**  * Children who have a known diagnosis, chromosomal, metabolic or genetic disorder, inborn or acquired disorders resulting in long term complex needs or disability

 * Pre-school children who are presenting with a developmental delay or disorder in more than three domains, one of these domains must include GROSS MOTOR. ASQ results or a developmental profile should be included with the referral where possible.

 * Children who are presenting with motor difficulties and/or neurological abnormalities.

 * Children who are showing signs of regression of development with loss of skills.

 * School aged children with significant and complex learning difficulties (who have not previously undergone medical investigations) for investigation regarding the potential of an underlying medical cause for their difficulties. Evidence of learning levels and an Educational Psychology report should be provided from the school with the referral where possible.

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Medway Community Healthcare CIC providing services on behalf of the NHS

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Registered in England and Wales, Company number: 07275637

# 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   |   |
| What is the family’s first language?Is an interpreter required for health appointments? |  |

**Who else works with the family or child?**

|  |  |
| --- | --- |
| \*GPs name and address  |   |
| Hospital doctors name and address Including specialist and local hospitals |   |
| Other services child known to: | *e.g Physiotherapy,* |

**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 to the child health service?  |   |   |

|  |  |
| --- | --- |
| \*Referrers name and address  |   |
| \*Email address  |   |

**Pathway specific questions**

**Which services are you referring to?**

|  |  |
| --- | --- |
| **Service**  | **Service**  |
|   | Paediatrician |   | Physiotherapy  |
|   | Occupational therapy  |   | Speech and language therapy |
|   | Dietician |   |  |
| Other – please state:  |  |

Referral will be triaged to the most appropriate health professionals based on the information given below.

***Please complete all boxes to the best of your ability.***

***If your referral does not meet criteria or is not completed with sufficient detail it may be rejected.***

|  |  |
| --- | --- |
| 1. What are the main concerns/reasons for this referral? |       |
| 2. What are you hoping the outcome of this referral will be? |      |
| 3. Does the child have a known diagnosis? If yes, please provide more information |            |
| 4. Please list any interventions that the have been implemented for this child, relating to these concerns?   |         |
| 5. What is the impact of these concerns on the child?  |       |
| 6. Is the child on any medication? If yes, please list.  |       |
| 7. Is the child making progress?  |    |

|  |
| --- |
| 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  |  | Social smile  |  |
| Babble |  | First words |  |
| Responded to name |  |  |  |

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| --- |
| Please add any other information that maybe relevant to this referral. |