Referral & Patient Registration Form for Children's Services

NHS Walsall

SECTION A

Baby, Child or Young Person's Details	NHS No:											
Surname:	**Forename(s):**										Also known as:	
DOB:					**Title:**	**Sex:** M / F						
Address: **Post Code:** ☐ Temporary ☐ Permanent					Correspondence Address (if different): **Post Code:** Parents/Carers wish to receive copies of letters, reports, referrals ☐ Yes ☐ No							
Contact Tel No(s):					**GP:**							
Ethnicity:	Religion:				**GP Address (or Bag No.):**							
Interpreter required?	**Language(s):**				☐ Registered Disabled ☐ Disabled Parking Required							
Personal Carer Information					**(NB: Personal Carer is the Main Carer with Parental Responsibility)**							
Next of Kin. Name:					**Relationship:**						**Sex:**	
DOB:	Ethnicity:				Religion:							
Address: Post Code:					Contact No:							
Other Carer Name:					Relationship:						Sex:	
DOB:	Ethnicity:				Religion:							
Address: Post Code:					Contact No:							
Medical Diagnosis/Difficulties:					**Current Medication:**							
Referral Details												
Referral date:	**Referring Agency:**				**Location/ Bag No.:**							
Referred by: Print name:					Signature:					Contact number:		
Referral Priority: ☐ Routine ☐ Urgent					**School or Nursery attended:**							
Reason for Referral: Continue over					Referral has been discussed with: ☐ Parent ☐ Carer ☐ Young Person Date: _____ Signed: _____ Is Child: ☐ On CP Register ☐ Adopted ☐ Travelling Family ☐ Looked After Children ☐ Child Concern							
Referred to Service/ Speciality * :					Referred to Team/Clinician:							
Any Additional Supporting Information: Continue over												

For Office Use Only:	
Date Received Referral:	**Purpose:**
Referral Reason:	**Authorisation:**
Referred to Team	**Referred to Clinician:**
Referral Rejection:	**Reason for Rejection:**
Signed by: _____ **Date:** _____	

*** If Referred to Speciality is Team Around Child, Physiotherapy, Speech & Language Therapy or Occupational Therapy, then please provide any appropriate additional Information in Section B Page 2 or for CAMHS please use additional supporting information section and refer to the guidance notes.**

SECTION B

Sub section i:

Referred to Speciality :

- ☐ Physiotherapy - Medical Referral Only
- ☐ Occupational Therapy - Medical Referral Only
- ☐ Speech & Language Therapy - Open Access
- ☐ Team Around Child (TAC) - Open Access
- ☐ Other - Please specify: _____

Hearing

- ☐ Satisfactory ☐ Problem Suspected
- ☐ Hearing Loss Confirmed

Vision

- ☐ Satisfactory ☐ Problem Suspected
- ☐ Visual Problem Confirmed

Birth History

Please describe concerns in any of the following areas – see notes for guidance

Gross Motor	**Fine motor**
Self-help (feeding, dressing & toileting)	**Visual Perception**
Attention & Concentration	**Behaviour**

Communication Skills (tick all that apply)

- ☐ No concerns ☐ Stammering ☐ Difficulty putting words together
- ☐ Voice problems ☐ Not using Words ☐ Difficulty understanding/following instructions
- ☐ Not pronouncing certain sounds ☐ Other communication problem - Please describe:

Sub section ii:

Does the child have any learning problems? Stage of Code of Practice: (if applicable)	National Curriculum Attainment Levels/Baseline Scores:

Sub section iii: Referral to SLT for problems with oral control for feeding/swallowing – medical referral only.

☐ Problems with oral control for feeding/swallowing

Please give details:

Sub section iv: To be completed if Referral to TAC

Is transport required? ☐ Yes ☐ No

Sub section v: Other services involved with the child:

- ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech & Language Therapy ☐ Sure Start ☐ N.C.H
- ☐ Pre-School Service ☐ Clinical Psychology ☐ Vision Impaired ☐ Hearing Impaired
- ☐ Social Worker ☐ Consultant (s) Name: _____ Name: _____

Any Additional Supporting Information:

Continue on new page if required

For Occupational Therapy, Physiotherapy or TAC please send referral to:	**For Speech & Language Therapy please send referral to:**	**For referrals to CAMHS:**
Child Development Centre Coalheath Lane Shelfield Walsall WS4 1PL Tel: 01922 858729	First Floor – Blakenall Village Centre Thames Road, Blakenall Walsall WS3 1LZ Tel: 01922 605400 ex.3 Fax: 01922 605405	In cases of emergencies or if you have any queries regarding a referral to the service please contact the Department on: 01922 424940