

The Children's Trust Referral Form

*** Please attach the child's latest medical and therapy report to this referral form***

Patient Information			
Child's name: Known as:		Child's NHS no:	
Date of birth:	Age:	Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>
Home address:			
Home telephone no:			
Parent's name: Relationship:		Parent's name: Relationship:	
Parent's address:		Parent's address:	
Parent's telephone no. (m) (h)		Parent's telephone no. (m) (h)	
Nationality:		Ethnic origin:	
Child's first language:		Interpreter required: Yes/No	
Parent's first language:		Religion:	
Other family members name:	Age:	Relationship to child:	
Name of GP:		GP address:	
Social Worker name and contact details:		Social/safeguarding concerns (please specify):	
Referral Information			
Service type: Residential Short Breaks		Holiday Camps & Clubs	
Name of Referrer:		Designation:	
Contact no:		Email:	
Date of referral:			
Reason for referral:			

Summary of current medical condition:		
Current medication:		
Lead consultant/Community Paediatrician:		
Email:		Telephone no:
Previous medical history:		
MRSA/Infection status: Yes/No		
Allergies:		
Community Nursing Team:	Telephone no:	Email:
Physiotherapist:	Telephone no:	Email:
Occupational Therapist:	Telephone no:	Email:
Speech and Language Therapist:	Telephone no:	Email:
School/nursery:		Current school year:
Address and contact details:		
Family's understanding and expectations of placement: (for residential short breaks Include number and frequency of required dates i.e midweek, weekends and school holidays)		

Clinical Information		
Please complete:	Please delete:	Further information if relevant:
Independently mobile	Yes /No	
Hoisted for all transfers	Yes /No	
Tracheostomy	Yes /No	
Ventilated	Yes /No	
Medically stable	Yes /No	
Enterally fed	Yes /No	
Effective means of communication	Yes /No	
1:1 supervision	Yes /No	
Behavioural concerns	Yes /No	
Emotional wellbeing/mental health concerns	Yes /No	
Self-Harm concerns	Yes /No	
Previous or current CAMHS involvement	Yes /No	

Data Protection

The Children's Trust takes your and your child's right to data privacy seriously and is committed to keeping your and your child's personal information safe. For full details, please see our privacy policy <https://www.thechildrenstrust.org.uk/privacypolicy>

Permission to Assessment & Sharing Information

Child/Young Person's name:

Permission to assessment

Following the referral of your child to The Children's Trust, healthcare professionals from the inter-professional team wish to carry out an assessment of their needs.

At times the Team at The Children's Trust will need to request further information from, and give information to, other professionals external to The Children's Trust, who have previously been, or may in the future be, involved in your child's care.

Permission to share information

I am a young person over 16 years

I am the parent/person with parental responsibility for the child named above:

- I give my permission to the assessment
- I give my permission to the sharing of information about my child's needs and circumstances, between health professionals within The Children's Trust team and externally where required; and informing local social services if my child is resident continuously for three months or more.

Signed:

Date:

Print Name:

Legal status: Parent / Person with Parental Responsibility **(please delete as appropriate)**

Relationship to child referred:

Data Protection: The Children's Trust takes your and your child's your right to data privacy seriously and is committed to keeping your and your child's personal information safe. For full details, please see our privacy policy <https://www.thechildrenstrust.org.uk/privacypolicy>