The Children's Trust
For children with brain injury

The Children's Trust Referral Form

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

Patient Information		
Childs name: Known as:	Child's NHS no:	
Date of birth:	Age:	Sex:
Home address:	CCG: Has CCG been notified of referral: Yes / No If not please notify CCG and enter date notified:	
Home telephone no:		
Parent's name: Relationship:	Parent's name: Relationship:	
Parent's address:	Parent's address:	
Parent's telephone number. (m) (h)	Parent's telephone number: (m) (h)	
Child's first language:	Ethnic origin:	
Parent's first language:	Nationality:	
Interpreter required: Yes/No	Religion:	
Sibling's names:	Age:	Relationship to child:
Name of GP:	GP address:	
Social Worker name and contact details:	Social/safeguarding concerns (please specify):	
Referral Information		
Service type: Rehabilitation (Please delete) LTV step down	Short Breaks Other, please state:	Brain Injury Community Team
Name of Referrer:	Designation:	
Contact no:	Email:	
Date of referral:	Date of injury:	
Child's current placement: please delete Home Hospital	If in hospital please state Hospital: Ward:	

<table>
<tr><td colspan="3">Reason for referral:</td></tr>
<tr><td colspan="3">Summary of current medical condition:</td></tr>
<tr><td colspan="3">Current medication:</td></tr>
<tr><td colspan="3">Lead consultant:</td></tr>
<tr><td>Email:</td><td colspan="2">Telephone number:</td></tr>
<tr><td colspan="3">Previous medical history, pre-morbid developmental history:</td></tr>
<tr><td>Visual assessment required: Yes/No</td><td colspan="2">MRSA/Infection status: Yes/No</td></tr>
<tr><td colspan="3">Allergies:</td></tr>
<tr><td colspan="3">Current rehabilitation goals:</td></tr>
<tr><td>Community Nursing Team:</td><td>Telephone number:</td><td>Email:</td></tr>
<tr><td>Physiotherapist:</td><td>Telephone number:</td><td>Email:</td></tr>
<tr><td>Occupational Therapist:</td><td>Telephone number:</td><td>Email:</td></tr>
<tr><td>Speech and Language Therapist:</td><td>Telephone number:</td><td>Email:</td></tr>
<tr><td>Psychologist:</td><td>Telephone no:</td><td>Email:</td></tr>
<tr><td colspan="3">Family’s understanding and expectations of the child’s placement and current discharge plans:</td></tr>
<tr><td>School/nursery:</td><td colspan="2">Current school year:</td></tr>
<tr><td colspan="3">School/nursery address and contact details:</td></tr>
<tr><td colspan="3">Has school been contacted? Yes / No
If so please provide details of contact:</td></tr>
<tr><td colspan="3">Any known special educational needs? Please specify:</td></tr>
<tr><td colspan="3">Does the child have an EHCP or SEN?</td></tr>
</table>

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	
Orally 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	

The Children's Trust Consent Form

The Children's Trust
For children with brain injury

Consent to Assessment & Sharing Information

Referral to The Children's Trust

Child/Young Person's name: …………………………………………………..

Following the referral of you/your child to The Children's Trust a member of the multi-professional team would like to visit you and your child to determine whether a placement at The Children's Trust would be appropriate.

In order to gather information prior to visiting you the Team at The Children's Trust will need to request further information from, and give information to, other professionals involved in your child's care including where necessary your child's school and social worker.

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

I am the young person named above and I am over 16 years of age ☐

I give permission to The Children's Trust team to visit me/my child to assess whether a placement at The Children's Trust would be appropriate.

Signed: ______________________ Date: ______________

Print Name: ______________________ Relationship to child: ______________

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

Relationship to child referred: …………………………………………………..