**The Children’s Trust Referral Form**

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| **Referrer Details** | |
| Date of referral: | Referrer name: |
| Referrer designation: | Referrer contact details: |

Please circle the service you’re referring to:

Neurorehabilitation Short Breaks Step-down Community

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| **Child Information** | |
| Name: | Gender: |
| Age & date of birth: | Current location (include ward name): |
| Home address: | NHS number: |
| First language: | Interpreter required: |
| Ethnic origin: | Nationality: |
| GP surgery (include GP name if known): | |

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| **Social / Family Information** |
| Parents names: |
| Parents address, if different from child: |
| Parents contact details: |
| Community social worker name & contact details: |
| Current family wellbeing and support needs: |
| Are there any potential discharge barriers e.g., housing? |

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| **Safeguarding** |
| Is the child currently or have they been previously known to social services? |
| Is the child currently or have they previously been subject to a section 17 (child in need), section 47 (child protection), or section 20 / section 31 (looked after child) plan, investigation, or order? |
| Are there any adults associated with family that cannot have contact with the child? |

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| **Referral Information**  Please complete as applicable to service referring to. |
| Reason for referral: |
| Date of injury: |
| Cause and type of injury: |
| Medical history, including allergies and medications: |
| Is the child currently medically stable: |
| Current infection status:  *Is the child colonised or actively infected?* |
| Current rehabilitation goals: |
| Any known special educational needs, including EHCP: |
| Is there any current or previous CAMHS involvement: |

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| **MDT Contact Details** |
| Lead Consultant name & contact details: |
| Therapist’s names & contact details: |
| School name & contact details: |
| Other community/hospital MDT names & contact details: |

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| **Current Presentation/Clinical Needs** |
| **Mobility**  *Summarise child’s current mobility needs and any equipment.* |
| **Communication**  *Summarise child’s current communication needs and any equipment.* |
| **Respiratory**  *Summarise child’s current respiratory needs and any equipment.*   * *Oxygen, suctioning, tracheostomy, ventilation* |
| **Transfers**  *Summarise how the child transfers and any equipment.* |
| **Eating & drinking**  *Summarise child’s current eating & drinking needs.* |
| **Behaviour**  *Summarise child’s current behaviour needs.*   * *Are there any behavioural concerns, how do these present?* * *Does the child require additional supervision due to behaviour needs?* * *Is there any risk to others?* |
| **Emotional health/wellbeing**  *Summarise child’s current emotional health/wellbeing needs.*   * *Are there any emotional health/wellbeing concerns, how do these present?* * *Are there any current or previous self-harm concerns?* |
| **1:1 needs**  *Does the child require 1:1 supervision?*  *What is this supervision for?* |

**Please send referral form with recent medical/therapy reports and signed consent form to:**

**placements@thechildrenstrust.org.uk or childrenstrust.tctplacements@nhs.net**

**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.

Date:

Signed:

Print name:

Legal status:

Relationship to child referred: