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| SPECIALIST AND CHILDREN’S SERVICES**SINGLE POINT OF ACCESS MULTI-AGENCY REFERRAL FORM** |

**Referrals will be accepted from any health, social care/MAT, educational (SENCO) or 3rd sector service via**

**Email:** dhcft.SPOA@nhs.net

**Post:** Single Point of Access, Temple House, Mill Hill Lane, Derby DE23 6SA

**Tel:** If you need to discuss a new or existing referral the SPOA Administrator can be contacted on 0300 7900 264

**Please Note**: The information contained in this form will be used by the Single Point of Access team to identify the most appropriate service to meet the needs of the child. The Information on this referral form shall be used in accordance with the permissions granted by you and in accordance with GDPR and the Data Protection Act 2018. Derbyshire Healthcare NHS Foundation Trust is the Data Controller for the purposes of the Act and can be contacted at Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ. The Data Controller is committed to protecting your privacy and will collect, store, use and share the data when appropriate and only for the purposes relating to this form. For a full explanation and further information on your rights please see the Data Controllers privacy notice here

<https://www.derbyshirehealthcareft.nhs.uk/privacy-policy>

**PART A**

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| **Patient details** |  | **Referrer** |
| Forename | Click here to enter text. |  | Name | Click here to enter text. |
| Surname | Click here to enter text. |  | Designation | Click here to enter text. |
| Address | Click here to enter text. |  | Base address | Click here to enter text. |
| Postcode | Click here to enter text. |  | Telephone no. | Click here to enter text. |
| Date of birth  | Click here to enter text. |  | Email | Click here to enter text. |
| NHS number | Click here to enter text. |  | Date of referral | Click here to enter a date. |
| **School/nursery name** | Click here to enter text. |  |  **GP Details** |
| School/nursery AddressTelephoneSenco/Keyworker nameContact email |  |  | GP name and Practice name |  |
| Home language | Click here to enter text. |  | AddressPost Code |  |
| Interpreter needed | Yes |[ ]  No |[ ]   | Telephone |  |

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| **Family \ carer information**  |
|  Who looks after the child?in what capacityParental responsibility to child/YP Telephone number/s (home and mobile)EmailAddress if different to child/YP | Name:Birth Parent Adoptive parent Carer other Yes/No |
| Who looks after the child?In what capacityParental responsibility to child/YP Telephone number/s (home and mobile)EmailAddress if different to child/YP | Name:Birth Parent Adoptive parent Carer other Yes /No  |

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| **Consent- Please ensure you complete this section as the referral will be rejected without completed consent.** |  | **Yes** |  | **No** |
| Parental/ Carer consent given for this referral? **The referral will be returned if consent is not gained.**  |   |  |  |  |
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| Parental/ Carer consent given for access to the child’s paper and electronic health records? **The referral will be returned if consent is not given.** |  |  |  |  |
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| Child/ Young Person consent given for this referral (if applicable/ appropriate) |  |  |  |  |
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| Parental/ Carer consent for us to liaise with past or presently involved professionals and agencies |  |  |  |  |
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| If No, please specify: |  |  |  |  |
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| The therapist/clinician can visit my child at school/nursery for short-notice appointments, without my specific consent each time. |  |  |  |  |
| Parents/carers consent to SMS text messages for correspondence/reminders for appointments. If yes, please state preferred mobile number:**\***Consent for professional to email parent/carer personal information about their child.If yes, please state parent email address:**\*:** |  |  |  |  |
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Parental/Carer consent to this referral being signposted to the most relevant agencies if deemed inappropriate for Community Paediatrics or the Neurodevelopmental Pathway (This may include, mainstream CAMHs, School Nursing, Learning/Intellectual Disability Services, Speech and Language Therapy).

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| Which other professional \ services are involved with the family? *(Please provide contact details)* |
| Click here to enter text. |
| **PART B.****Referral information** |
| **Reason for referral:** |
| **If the referral is for a neurodevelopmental assessment for Autism spectrum disorder/ADHD, please indicate this-Tick the relevant box/esNB: we do not accept referrals for ADHD assessment if under 51/2 years old** | Autism spectrum disorder  ADHD (if >51/2 years old)  |
| **Details of concerns** Please give details of practitioner and parent/carer concernsPlease include details on:current concernsHow long the concerns have been present forHow these difficulties may affect the child or young person in their daily life?

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| Areas of life where concerns are evident? | School |[ ]  Home |[ ]  Social/other areas |[ ]

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| Medical history, including any specific assessment which may have already been completed and specific diagnoses already known: |  |
| Details of any current medication |  |
| Any known allergies? If yes, please give details |  |

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| **Development** Please give details of practitioner and parent/carer concerns |
| Motor skills (Gross motor and fine motor)-Speech and Language-Personal and Social skills-Any regression of development- |

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| **Specific concerns** |
| Abuse |[ ]  Self-harm |[ ]  Hyperactivity |[ ]
| Anxiety/phobias |[ ]  Low mood |[ ]  Poor concentration |[ ]
| Attachment needs |[ ]  Obsession +/- compulsions with fear |[ ]  Social/communication difficulties |[ ]
| Post trauma symptoms |[ ]  Stress |[ ]  School exclusion or threat of |[ ]
| Bereavement |[ ]  Parental mental health needs |[ ]  Learning needs/disability- if ticked, please enclose assessments done |[ ]
| Eating/weight difficulties |[ ]  Vocal or motor tics |[ ]  Behavioural problems |[ ]
| Family breakdown |[ ]  Suicidal thoughts/threats |[ ]  Physical disability |[ ]
| Hearing voices |[ ]  Substance misuse |[ ]  Peer bullying |[ ]

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| **Details of above concerns and anything else you think we should know** |
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| **Social and family history** Include parents, siblings, relevant family circumstances and any known risks.  Please fill in Detail Section in addition to ticking boxes |
| Parent mental health concerns |[ ]  Parent physical health concerns |[ ]  Sibling physical health concerns |[ ]
| Parent disability |[ ]   |  | Sibling disability |[ ]
| Substance abuse |[ ]  Domestic abuse |[ ]   |
| **Details** and any other relevant information such as family separations, stressful life events or other experiences  | Click here to enter text. |

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| **Special educational needs and disability (SEND)**Does the child have? (Please provide copies) |
| Identified SEND  |[ ]  GRIP funding |[ ]
| Education Health and Care Plan |[ ]   |[ ]

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| **Safeguarding**Are any of the following in place for the child? (Please provide copies) |
| Early Help Assessment (EHA)  |[ ]  Child in need support |[ ]
| Child protection plan |[ ]  Child looked after by the Local Authority |[ ]
| Does the patient or family have any safeguarding concerns? (If yes, please specify) | Click here to enter text. |

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| **Support provided (please provide evidence of support offered by universal services and graduated response prior to referral to specialist services, or the referral will be returned)**

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| Parenting course  |[ ]  Early help assessment | [ ] [ ]  |
| Education- Graduated response |[ ]  Other  |  |

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| **Neurodevelopmental referral (i.e., concerns about possible autism spectrum disorder and/or ADHD) Note to referrer**To enable the professionals to make appropriate decisions please ensure you have enclosed the following paperwork with this referral. Failure to do so will result in the referral being returned.1. Parent/carer questionnaire completed

1. Teacher questionnaire - nursery/primary or secondary form completed

1. Vanderbilt questionnaires completed by both parent and teacher if aged 6 or over

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