Please use this form for all children under the age of 16

Please try to give as much information as possible to aid the triage of the referral

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient and Family Details** | | | | |
| Childs Name |  | DOB |  | |
| NHS Number |  | | | |
| Address |  | | | |
| Parent / Carer Name |  | | | Parental Responsibility?  Y /N |
| Contact Number |  | | | |
| First Language |  | Interpreter required? Y / N | | |
| School / Nursery |  | | | |
| GP |  | | | |
| GP Address |  | | | |

|  |
| --- |
| **Please obtain Parent/Carer Consent to make this referral**  (Referrals without consent will not be reviewed) |
| I am aware of the reason for this referral and consent to the referral being made. I understand that this referral may be discussed and shared with other services if it is felt appropriate (listed below) in order for additional or alternative service referrals to be made. I consent for information to be shared for this purpose.  **Parent Signature**: **or Verbal consent from (name of parent**):  *The paediatric services which this referral may be passed to are: Paediatrician, Occupational Therapy, Portage, Speech and Language Therapy, Health Visitors and School Nurses.* |

|  |  |  |
| --- | --- | --- |
| **Safeguarding** | | |
| None  LAC    CIN | EHA  Concerns please give details  CP | Extra Information: |

|  |  |
| --- | --- |
| Name of Social Worker |  |
| **Reason for Referral:** | |
| When did the problem start? | |
| How is the problem affecting the daily life of the child? | |
| Is the problem an acute flare up of a chronic problem? | |
| Are there any neurological concerns? Please give details: | |
| Has the child previously had Physiotherapy for this problem? | |

|  |  |  |
| --- | --- | --- |
| Other medical history (please include serious illness, accidents and birth history where appropriate) | | |
| EHCP | Yes / No | |
| Investigations and results? | | |
| Other professionals involved? | |  |
| Any other relevant information | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer details** | | | |
| Name | |  | |
| Job Title | |  | |
| Address | |  | |
| Contact Number | | |  |
| Date |  | | |

Please return this form to [**paediatric.ptotreferrals@nhs.net**](mailto:paediatric.ptotreferrals@nhs.net)

**Office Use Only:**

**Urgent Gait clinic**

**Soon MSK clinic**

**Routine General waiting list**