**Lancashire Teaching Hospitals NHS Foundation Trust Community neurodevelopmental paediatrics referral form – Parent/Carer**

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| **Child/Young Person’s Details** |
| Name of Child/Young Person |  |
| Date form Completed |  | Date of Birth |  | NHS Number (If know) |  |
| Home address (inc postcode) |  | Mobile Number  |  |
| Gender |  | Ethnic Group |  |
| Spoken Language |  | Interpreter required | Yes [ ]  No[ ]  |
| Name of GP |  | Address of GP |  |
| Nursery/school/college |  | Email address |  |

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| **Consent** |
| It is **essential** that this consent form is completed as without which the referral will not be accepted.If the child/Young person is under 16 years of age the parent/carer should provide consentIf between 16-25 years of age, the young person should complete the form themselves and sign the consent. |
| Signature of parent/guardian (if child under 16 years) ..………………………………………………………….Date ………………….Name …………………….……………………………………………………………………………ORSignature of young person …………………………………………………………. Date ………………………………… |

**Section 1: Views, Interests and Aspirations**

**My One-Page Profile**

If this Profile has already been completed, for example by your child’s

school or nursery, please provide a copy.

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| My name is |       |

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| What people like about me and what I like about myself |
|       |

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| --- | --- | --- |
| What is important to me |  | How I communicate |
|       |  |
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| How best to support me |
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| Aspirations: What I would like to do in the future |
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| How these views were gathered Date:       |
|       |
| **Please describe current concerns about your child/young person in relation to their:** |
| **Social communication** (How do they ask for things, non-verbal communication (eye contact, facial expression, gestures), any unusual speech?) |
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| **Social interaction**  |
| **How does your child or young person get on with other members of the family?** |
| **How does you child or young person get on with other children/young people?** |
| **Does your child or young person**  |
| Make and maintain friendships? | **Yes**[ ]  | **No**[ ]  |
| Have any close friendships?  | **Yes**[ ]  | **No**[ ]  |
| Share interest and enjoyment with you or others? | **Yes**[ ]  | **No**[ ]  |
| Initiate interaction with others? | **Yes**[ ]  | **No**[ ]  |
| Understand the feelings of other people? | **Yes**[ ]  | **No**[ ]  |
| Understand how to behave in different situations? | **Yes**[ ]  | **No**[ ]  |
| Show concern for others who are hurt of upset? | **Yes**[ ]  | **No**[ ]  |
| Change mood quickly and drastically | **Yes**[ ]  | **No**[ ]  |
| Cries easily | **Yes**[ ]  | **No**[ ]  |
| Comments: |
| **Behaviour** (behaviour outbursts / play skills / empathy skills / routines / repetitive behaviours etc.) |
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| **Sensory behaviours** (preferences for food, smell, clothing, noises etc.) |
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| **Attention / concentration** (organisation and ability to sit and complete tasks)  |
| **If you have concerns with attention/concentration, please see appendix A** |
| **Hyperactivity & impulsive behaviours** |
| **If you have concerns with hyperactivity and impulsive behaviours, please see appendix A** |
| **Please describe the current living circumstances – do the parent/carers have the same address? Do they have siblings? How many? Do they live in the same household?** |
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| **Have there been any significant life events e.g. bereavements?** |
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| **History of development**  |
| **How was your child delivered and did they require any after birth care?** |
| **Normal** |[ ]
| **C-Section** |[ ]
| **Ventouse/Forceps** |[ ]
| **Comments:** |
| **At or after delivery** |
| **Resuscitation needed** | **Yes**[ ]  | **No**[ ]  |
| **Admitted to special**  | **Yes**[ ]  | **No**[ ]  |
| **Feeding difficulties** | **Yes**[ ]  | **No**[ ]  |
| **Postnatal depression** | **Yes**[ ]  | **No**[ ]  |
| **Comments:** |
| **Birth Details** |
| **Did you/your child’s mother have any health concerns during pregnancy?** |
| **Did you/your child’s mother take any medication during pregnancy (if so, what did you take)?** |
| **Is there a history of smoking/ drinking alcohol/ substance misuse (drugs) during pregnancy?** |
| **How long was the pregnancy in weeks (full-term is 37 to 40 weeks)** |
| **What was your child’s birth weight** |
| **Early Development** |
| **Were any of the following areas of your child’s development of concern to you after birth** |
| **Gross motor skills – sitting, walking, running** | **Yes**[ ]  | **No**[ ]  |
| **Any regression of gross motor skills** | **Yes**[ ]  | **No**[ ]  |
| **Fine motor skills – picking up and handling toys or cutlery, drawing, cutting or tying shoe laces**  | **Yes**[ ]  | **No**[ ]  |
| **Language – what age did they speak words other than mama and dad?** | **Yes**[ ]  | **No**[ ]  |
| **Any speech regression**  | **Yes**[ ]  | **No**[ ]  |
| **Hearing**  | **Yes**[ ]  | **No**[ ]  |
| **Eyesight** | **Yes**[ ]  | **No**[ ]  |
| **Self-help skills – dressing, feeding, toileting**  | **Yes**[ ]  | **No**[ ]  |
| **Play skills** | **Yes**[ ]  | **No**[ ]  |
| **Imaginative or pretend play skills – copying household activities, dressing up or laying with dolls or teddies or small world play** | **Yes**[ ]  | **No**[ ]  |
| **Aggressive or irritable behaviour**  | **Yes**[ ]  | **No**[ ]  |
| **Loss of any skill they previously had** | **Yes**[ ]  | **No**[ ]  |
| **Please outline any concerns about early development here:** |
|  |
| **Strengths and interests**  |
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| **Sleep** |
| **Screentime/iPad/TV** | **Bedtime**  |
| **Please detail evening routine before bedtime** | **How many total hours of screentime during the weekdays:****How many hours of screentime in the evening on weekends:**  |
| **Education** |
| **Name of the preschool/nursery or school attended. Please write home schooled stating the reasons why the child is/was home schooled if applicable**  |
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| **Please describe difficulties the child experienced during their preschool, nursery or primary or secondary school years as applicable (bulling, running away from school, social isolation, poor school attendance, exclusions etc.)** |
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| **Please describe any extra support the child or young person received at preschool nursery, primary or secondary school.** |
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| **Does the child / young person attend any groups or clubs?** |
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| **Mental and emotional wellbeing** |
| **Please tick against any concerns you have about your child’s or Young Person’s emotional well-being:** |
| [ ] **Anxiety** | [ ] **Fear or phobias**  | [ ] **Obsessive Compulsive Behaviours**  |
| [ ] **Hyperactivity** | [ ] **Hallucinations** | [ ] **School attendance issues/exclusion** |
| [ ] **Mood swings** | [ ] **Eating Disorder** | [ ] **Anger**  |
| [ ] **Low mood** | [ ] **Destruction of property like arson** | [ ] **Aggression to people or animals in the form of using a weapon, threatening, being cruel etc.** |
| [ ] **Bereavement** | [ ] **Suicidal ideation** | [ ] **Domestic violence** |
| [ ] **Impulsivity** | [ ] **Self-harm** | [ ] **Drug or alcohol use or addiction**  |
| [ ] **Short attention span** | [ ] **Breaking into someone home or stealing** | [ ] **Running away from home or school** |
| [ ] **Criminal activity/antisocial behaviours and or** [ ] **involvement with Youth Offending Team** |  |  |
| **Has your child ever had treatment (including hospitalisation) by, or is currently seeing, a psychiatrist, psychologist, therapist, or counsellor?** | **Yes**[ ]  | **No**[ ]  |
| **If yes, please give the following details: Nature of the concerns; start and end date of support; where seen and clinicians name; type of support, for example: counselling, play therapy, cognitive behaviour therapy, group work, family work, parent support and advice.** |
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| **Anything else you would like to tell us?**  |
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| **Completed by:****Date:**  |

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| **Return of Form** |
| Ensure all relevant reports and screening tools are attached and returned to: |
| By post: Community Neurodevelopmental Paediatric Service, Department of Child Health, Broadoaks CDC, Balcarres Road, Leyland, Preston PR25 3EHPlease ensure that correct postage is applied as we are unable to collect items from the post office with insufficient postage.By E-mail: BroadoaksCommunityClinics@LTHTR.nhs.ukIn the subject line you must enter: ND REFERRALPlease note that referrals can only be processed once both Part A and Part B have been received. Failure to follow the above instructions will result in delays in processing.Thank you. |

**APPENDIX A**

ADHD Referral Guidance (ADHD NICE guidance NG87)

* For the referral to be screened by the team, please ensure you have attached any relevant documentation/evidence including: SNAP IV forms, School assessment forms (including learning levels), relevant social care assessments, Paediatric Clinic letters? and EHCPs. **Referrals that do not contain the necessary information will be returned to source.**
* Referrals can be made by a lead professional; this will be the professional who knows the family best, has regular contact with the family and is able to collate the supporting evidence above. This may be a School Nurse, Health visitor, SENCO, Social Worker etc. Please ensure consent is gained from the family, in certain cases the young person, for the service to discuss and share information as we work in partnership with other agencies.
* Referrals will need to be in collaboration with the Child or Young Person’s school including teachers or Special Educational Needs Coordinators as evidence of the graduated approach is required.
* Please click the following link to access the SNAP-IV form. This will open as a PDF document. Once completed this should be attached to the referral. Failure to complete the form in its entirety will result in the referral being returned. **INSERT LINK HERE**