**CHILDREN’S LEARNING DISABILITY NURSING TEAM REFERRAL FORM**

(INADEQUATELY COMPLETED FORMS WILL BE RETURNED TO THE REFERRER)

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| **\* CHILD / YOUNG PERSON’S DETAILS:** | | | | **Referral Date: / /** | | | | | | | | | |
| **Name:** |  | | | **Date of Birth:** | | | |  | | **Age:** | |  | |
| **Is the child/young person known by any other surname?**  **No**  If yes, please specify: | | | | | | | | | | | | | |
| **NHS Number:** |  | | | **Gender:** | | |  | | | **Ethnicity:** | | |  |
| **Usual Address:** |  | | | **Tel No:** | | |  | | | | | | |
| **Mobile. No:** | | |  | | | | | | |
| **Email address:** | | | | | | | | | |
| Tick if the appointment needs to be made by telephone (e.g. for literacy reasons) | | | | | | | | | |
| **GP Name & Address:** |  | | | **School/Nursery/ College:** | | | | |  | | | | |
| **Tel:** |  | | | **Tel:** | | | | |  | | | | |
| **Does the child / young person have a learning disability?** | | | | | | | | | | **Yes  No** | | | |
| **Does the child / young person have a diagnosis of Autism and is under 11?** | | | | | | | | | | **Yes  No** | | | |
| **Identified Physical Health Problem?**  If yes, please give details: | | | | | | | | | | **Yes  No** | | | |
| **Has the child / young person been referred previously to the Children’s Health Services?**  If yes, which service, when and with what outcome? | | | | | | | | | | **Yes  No** | | | |
| **Has an Early Help form been initiated (please attach)** | | | | | **Yes  No**  **Unknown** | | | | | | | | |
| **Does the child / young person have an Education, Health and Care Plan? Yes**  **No**  **Unknown** | | | | | | | | | | | | | |
| **Are there any safeguarding issues? Yes**  **No**  **Unknown** | | | | | | | | | | | | | |
| **Does the child / young person have an open referral with CAMHS?**  **No Yes**  **No** | | | | | | | | | | | | | |
| **Interpreter required Yes**  **No** | | | | | | | | | | | | | |
| **British Sign Language required Yes**  **No** | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | |
| **\* PARENT / CARER DETAILS:** | | | | | | | | | | | | | |
| **Full Name(s) of Parent(s) / Guardian(s):** | | | | | **Parental Responsibility held by:** | | | | | | | | |
| **1) First Name:** | | | **Surname:** | | |  | | | | | **Yes  No** | | |
| **2) First Name:** | | | **Surname:** | | | | | | | | **Yes  No** | | |
| **Who is the child living with?** | |  | | | | | | | | | | | |
| **Siblings names and ages:** | |  | | | | | | | | | | | |
| **Permission to leave a message? yes** | | | | | **Yes  No** | | | | | | | | |
| **Do any of the parents / carers have learning difficulties? Yes  No** | | | | | | | | | | | | | |
| **Has the child/young person given consent for the referral? Yes**  **No**  If no, please state reason: | | | | | | | | | | | | | |
| **Has the parent given consent for the referral? Yes**  **No**  If no, please state reason:  *(Please note that we are unable to see children without agreement)* | | | | | | | | | | | | | |
| **Has the parent given consent for the service to access child’s record to gain information about diagnosis appropriate to the referral? Yes  No**  If no, please state reason: yes  (Please note that we are unable to accept referrals without gathering information about diagnosis) | | | | | | | | | | | | | |

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| **\* REFERRER DETAILS:** | | | |
| **Referrer’s Name:** |  | **Profession:** |  |
| **Address:** | |  | | --- | |  | |  | | | |
| **Tel. No:** |  | **Signature of Professional:** |  |

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| **Has the Child/Young Person been seen by you as a Referrer?** |
| **Yes  No** |

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| **REASONS FOR REQUEST (please continue in additional information section below, if necessary):**  **Include Diagnosis (if applicable)** |
| **Please clearly identify the reason the referral, including the child’s / young person’s difficulties and abilities, and the impact this has on his/her life:** |
|  |
| **What has been previously tried and what was the outcome e.g. Services or Intervention? Action or Advice given?** |
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| **Background/Family History/Social Circumstances:** |
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| **Past History of problems:** |

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| **Identified Risk:**  *Please inform us of any known risks in relation to the child/young person being a risk to themselves or others; any risk to child/young person from others (e.g. sexual exploitation, sexual abuse, physical abuse) or any risk that may potentially occur to staff whilst working with this child/young person or family.* |
|  |
| **What are your expected outcomes of this referral?** |

**PLEASE ATTACH ANY RELEVANT DOCUMENTATION**

**(e.g. early help assessment form, etc)**

**Please send to:** [**CumbriaChildrensLD@CNTW.nhs.uk**](mailto:CumbriaChildrensLD@CNTW.nhs.uk)

**Children’s Learning Disability & Behaviour Support Service**

**Unit 23**

**Lillyhall Business Centre**

**Jubilee Road**

**Workington**

**CA14 4HA**

**01900 705081**

**Children’s Learning Disabilities Nursing Team**

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| **Office Use:** | | | |
| **Date Received:** |  | **Date Entered Onto RiO:** |  |