

**Form updated May 2023**

**REFERRAL FORM FOR IANDS AND COMMUNITY PAEDIATRICS**

**SERVICES**

Speech and Language Therapy

Occupational Therapy

Developmental Paediatrician

Physiotherapy

Dysphagia (eating/swallowing safety)

Dietetics

current weight must be included

Social Communication Team

assessment and intervention for autism for under 5 years

(**For assessment of autism in 5-18yrs, refer to CAMHS**)

***Please note that we can only accept referrals with complete information. If information is missing, we may have to return the form for completion before it can be considered. Please attach any relevant reports / documentation to support the referral.***

**REFERRER’S DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer name\*** |  | **Phone\*** |  |
| **Job title** |  | **Email\*** |  |
| **Address\*** |  | | |
| **Date** |  | **Signed** |  |

**CHILD/YOUNG PERSON**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child’s Name\*** |  | | **Date of Birth\*** |  |
| **Parent’s Name** |  | | **NHS No** |  |
| **Address\*** |  | | **Postcode\*** |  |
| **Email\*** |  | | | |
| **Home Phone\*** |  | **Mobile\*** |  | |
| **GP and Address\*** |  | | | |
| **Health Visitor\*** |  | | | |
| **Nursery/School\*** |  | | | |

**ETHNICITY**

White - British

White - Irish

White - Gypsy/Romany

White - **Any other**

Mixed - White & Black Caribbean

Mixed - White & Black African

Mixed - White & Asian

Mixed - **Any other**

Asian or Asian British - Indian

Asian or Asian British - Pakistani

Asian or Asian British - Bangladeshi

Asian or Asian British - **Any other**

Black or Black British - African

Black or Black British - Caribbean

Black or Black British - **Any other**

Arab

Chinese

**Any other group**

Not known

Not stated

**Languages spoken**       **Interpreter needed** Yes  No

**FAMILY & PROFESSIONALS**

**Current family and home situation (if known): \****Child in Need – CIN /Child Protection – CP*

|  |
| --- |
| Who lives at home |
| Significant others in child’s life |
| Are there any known risks in visiting the home Yes  No |
| Are there any safeguarding concerns? CIN  CP |
| Is this child Looked After? Yes  No |

**Other professionals involved** *(please specify Name and details if known):*

|  |  |
| --- | --- |
| Paediatrician |  |
| Clinical psychologist/CAMHS |  |
| Educational Psychologist |  |
| Social worker |  |
| Family support worker |  |
| Audiology/ENT |  |
| Hospital Team |  |
| Therapist |  |
| Others |  |

**REFERRAL REASON**

**Please describe the reasons for this referral** *(give detailed information to help us address your referral)*

**What are the parental concerns?**

**Birth history where relevant:**

**Please outline concerns in the following areas:** *(only complete sections relevant to this referral)*

|  |  |
| --- | --- |
|  | **Please include relevant test results / observations to support the referral** |
| Physical health |  |
| Eating /Drinking /Swallowing |  |
| Growth  (*include weight/length/height*) |  |
| Enteral Feeding Regimen |  |
| Learning Skills |  |
| Language Skills (understanding and using words) |  |
| Social communication/interaction |  |
| Gross Motor Skills e.g. walking, running, climbing stairs |  |
| Fine Motor Skills/activities e.g. mark making, writing, typing, puzzles |  |
| Self Help Skills e.g. toileting, dressing |  |
| Vision |  |
| Hearing |  |
| Behaviour |  |
| Sensory processing, e.g. sensitive to noise, touch etc |  |
| Play and leisure e.g. community outings |  |
| Speech sounds (pronunciation) |  |
| Fluency (stammering) – Islington children and young people who require support for stammering are seen by the Speech and Language Therapy team at the Michael Palin Centre (MPC). Professionals or parents can refer using the online referral form on the MPC website: <https://michaelpalincentreforstammering.org/referrals/refer-my-child/> | |

Does the parent / carer have any additional needs or disabilities Yes  No

Please give details

**CONSENT**

**Please answer number 1 & 2 if referring to the autism pathway/social communication team**

1. **Does the parent/carer consent to this referral**? Yes  No
2. Please confirm that the parent/carer has given their informed consent for the **sharing of information** between the services of Whittington Health and London Borough of Islington and partners.

Yes  No

***Please email this form to*** [whh-tr.islchildrensreferrals@nhs.net](file:///C:\Users\parsonss\AppData\Local\Microsoft\Windows\INetCache\igebabat\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\XLVHFBDM\whh-tr.islchildrensreferrals@nhs.net)

**Please send a copy to the child’s GP and keep a copy for your records.**

**If you have any further queries, please call us on 020 3316 1877.**

**IANDS WEBPAGE** [Islington Additional Needs and Disability Service (IANDS) (whittington.nhs.uk)](https://www.whittington.nhs.uk/default.asp?c=25404)