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| GH LOGO**Gloucester House Referral Form** |

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| **DATE OF REFERRAL**  | **REFERRER** | **REFERRER CONTACT DETAILS** |
|  | **Referrer Name:****Role of Referrer:** **Referring Agency:** **Referral Source i.e. NHS, Social care etc. :** **Borough:** | **🕿****🖂** |
| **PROFILE INFORMATION: *\*(ALL FIELD BELOW ARE MANDATORY)\**** |
| **Forenames:** **Surname:** **Address:** **Postcode:**  | **DOB:** **Age:** **Gender:**  |  |
| Ethnicity  |
| (A) White British(B) White Irish(C) Other White background(D) White and Black Caribbean | (E) White and Black African(F) White and Asian(G) Other mixed background(H) Indian | (J) Pakistani(K) Bangladeshi(L) Other Asian background(M) Caribbean | (N) African(P) Other Black background(R) Chinese(S) Any other ethnicity group |
| **Religion:**  | **Language spoken at home:** **Interpreter required?** Yes [ ]  No [ ]  |
| **Does the child have a physical disability?**Yes [ ]  No [ ]  | **Does the child’s main carer have a physical disability?**Yes [ ]  No [ ] **Any other needs that we should be aware of?** *(Please detail below)*  |
| **If yes, please detail below;** | **If yes, please detail below;** |
| **Has the family agreed to this referral?**  | Yes [ ]  No [ ]  |
| **Who has Parental Responsibility?** | **Name:**  | **Relationship:**  |
| **Are there any communication alerts?** *(E.g. no contact with mother/father)*Yes [ ]  No [ ]  | **Details:** |
| **Family Members** *(please include surname of each family member)* | **Address** | **CONTACT NUMBER(S)** |
|  |  | **Daytime tel. No.** |  |
| **Mobile No.**  |  |
| **Relationship:** | **Work no.**  |  |
|  |  | **Daytime tel. No.** |  |
| **Mobile No.**  |  |
| **Relationship:** | **Work no.**  |  |
|  |  | **Daytime tel. No.** |  |
| **Mobile No.**  |  |
| **Relationship:** | **Work no.**  |  |
| **Name of GP:**  |   |
| **GP Address:** | **Contact no:**   |
| **SAFEGUARDING INFORMATION:**  |
| **Current status** |
| **Current social care involvement?**  | Yes [ ]  No [ ]   |
| **Category: *(please select as appropriate)*****Child Protection (CP) □****Child in need (CIN) □** **Subject to Early Help □****Child in public care (LAC) □** |
| **If CIN or CP please confirm commencement date:**  |  |
| **If CP please confirm and category:** |  |
| **Date of initial Child Protection Case Conference (CPCC)****Category:** |  |
|  |
| **Social worker and Primary SEN contact information:**  |
| **Name:****Tel:****Email:****Department:**  | **Name:****Tel:****Email:****Department:**  |
| **Other relevant information:** |
| **Past status:** |
| **Past social care involvement?**  | Yes [ ]  No [ ]  Not known [ ]  |
| **Category: *(please select as appropriate)*****Child Protection (CP) □****Child in need (CIN) □** **Subject to Early Help □****Child in public care (LAC) □** |
| **If CIN or CP please confirm commencement date:**  |  |
| **If CP please confirm and category.** |  |
| **Date of initial Child Protection Case Conference (CPCC)****Category:** |  |
|  |
| **Social worker contact information:**  |
| **Name:****Tel:****Email** **Department:**  |  |
| **Other relevant information:** |
| **CLINICAL INFORMATION:** |
| **CAMHS involvement: (Y/N)** |  | **Current or Past?** |  | **Date of referral?** |  |
| **Reason for referral:** |
| **KEY CLINICIAN CONTACT INFORMATION:**  |
| **Name:****Address:**  | **Contact no:** | **Other contact information:**  |
| **Details of assessments taken to date (i.e. CAMHS generic, specialist (neurodevelopmental – ADHD, ASD , neurocognitive) Diagnosis):** |
| **Diagnosis:** |
| **Medication:** | **Current care plan/interventions:** |
| **Other agency involvement (i.e. YST, YOT, Family support, early intervention services, mentoring, counselling, SALT, occupation other)** |
| **EDUCATIONAL INFORMATION :** |
| **Unique Pupil Number (UPN):** | **School details:**  |
| **Current school/ placement details:** |
| **If pupil is not in education please give details here:** |  |
| **School name and address:** |  |
| **Contact Number:**  |  |
| **Full time / Part time?**  |  | **School /Placement type (i.e. mainstream/PRU)** |  |
| **Attendance percentage (last academic year):** |  |  |  |
| **Date of exclusion if child excluded:** |  |
| **(Or if excluded but remains on role please clarify):** |
| **Does the child have an EHCP?***(please forward a copy to us)*  |  | **(If Yes, what category?)** |  |
| **EHCP start date?** |  |
| **Number of adult that work with the child? (i.e. 1:1 or 2:1)** |  |  |
| **Current academic levels:** |  |
| **Please forward the following documents :**  | **Copy of Statement/EHCP****Educational Psychology Report****Annual review documentation** **Educational Report** **Safeguarding chronology if applicable****Any other relevant documents.**  |
| **Other comments:** |  |

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| **Please complete all fields on this form.****Please return completed forms to Gloucester House Admin Manager:****Gloucesterhouseadmin@tavi-port.nhs.uk** |