Referral Form

**\*(ALL FIELDS BELOW ARE MANDATORY)\***

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| --- |
| **REFERRAL INFORMATION** |
| Name of Referrer: |  | Date of Referral: |  |
| Role of Referrer: |  |
| Referrer Email: |  | Referrer Tel: |  |
| Referring Agency: |  |
| Referral Source | (i.e. NHS, Social care, School etc…) |
| Borough: |  |
| **CHILD PROFILE INFORMATION** |
| Forenames:Surname:NHS Number: |  | Date of Birth:Age:Gender: |  |
| Address (inc Postcode) |  |
| Ethnicity: Click or tap here to enter text. |
| Asian or Asian British(A) Indian(B) Pakistani(C) Bangladeshi(D) Chinese(E) Any other Asian background | Black or Black British(F) Caribbean(G) African(H) Any other Black background | Mixed/multiple ethnic groups(I) White and Black Caribbean(J) White and Black African(K) White and Asian(L) Any other Mixed or multiple ethnic background | White(M) British(N) Irish(O) Gypsy or Irish Traveller(P) Roma(Q) Any other White background | Other ethnic group(R) Arab(S) Any other ethnic group – please specify |
| Language spoken at home: |  | Interpreter required? | YES [ ]  NO [ ]  |
| Does the child have a physical disability?If yes, please provide details: | YES [ ]  NO [ ]  | Does the child’s main carer have a physical disability?If yes, please provide details: | YES [ ]  NO [ ]  |
| Any other needs that we should be aware of?  |  |
| **Who has Parental Responsibility?** |
| Name |  | Relationship |  |
| Are there any communication alerts? (E.g. no contact with mother/father)If yes, please provide details: | YES [ ]  NO [ ]  |
| **Family Members Contact details** |
| Full Name: |  | Relationship: |  |
| Address: |  | Contact NumbersMobileHome |  |
| Full Name: |  | Relationship: |  |
| Address: |  | Contact NumbersMobileHome |  |
| Full Name: |  | Relationship: |  |
| Address: |  | Contact NumbersMobileHome |  |
| GP Details |
| Name of GP: |  | GP contact number |  |
| GP Address (inc postcode): |  |
| **SAFEGUARDING INFORMATION** |
| **Current status** | **Past Status** |
| Current social care involvement?  | YES [ ]  NO [ ]  | Past social care involvement?  | YES [ ]  NO [ ]  NOT KNOWN[ ]  |
| Category: (please select as appropriate)If CIN or CP please provide commencement date: | Child Protection (CP) [ ] Child in need (CIN) [ ]  Subject to Early Help [ ] Child in public care (LAC) [ ]  | Category: (please select as appropriate)If CIN or CP please provide commencement date: | Child Protection (CP) [ ]  Child in need (CIN) [ ]  Subject to Early Help [ ] Child in public care (LAC) [ ]  |
| **If CP please confirm and category:** |  | **If CP please confirm and category:** |  |
| Date of initial Child Protection Case Conference (CPCC)Category: |  | Date of initial Child Protection Case Conference (CPCC)Category: |  |
|  |  |
| **Social worker contact information:** | **Social worker contact information:** |
| Name |  | Name |  |
| Tel |  | Tel |  |
| Email |  | Email |  |
| Department |  | Department |  |
| Other relevant information: |  | Other relevant information: |  |
| **Primary SEN contact information:** |  |  |
| Name |  |  |  |
| Tel |  |  |  |
| Email |  |  |  |
| Department |  |  |  |
| Other relevant information: |  |  |  |
| **CLINICAL INFORMATION** |
| CAMHS involvement? | YES [ ]  NO [ ]  | Current/Past? |  | Referral date: |  |
| Reason for referral: |  |
| **Key clinical contact information:** |
| Name:  |  | Contact no:Email:Other contact information: |  |
| Address: |  |
| 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): |  |
| If pupil is not in education, please give details here: |  |
| **Current school/ placement details:** |
| School name and address: |  | Contact Number: |  |
| Current provision type (i.e., mainstream/PRU) |  | Full time orPart time? |  |
| If part-time, please state daily attendance hours: |  |
| Attendance percentage (last academic year): |  |
| Date of suspension if child is suspended: |  |
| (If suspended but remains on roll please clarify): |  |
| Does the child have an EHCP?(If yes, what category?) | YES [ ]  NO [ ]  | (Please forward a copy to us) |
| EHCP start date? |  |
| Current academic levels: |  | No. of adults that work with the child? (i.e. 1:1 or 2:1) |  |
| Other comments: |  |
| **Please forward/attach the following documents:** | **Copy of Statement/EHCP****Educational Psychology Report****Annual review documentation** **Educational Report** **Safeguarding chronology if applicable****Any other relevant documents** |
| **Please ensure all fields on this form are completed, incomplete forms will be returned.****Please email completed forms to the Gloucester House Admin Manager:** **Gloucesterhouseadmin@tavi-port.nhs.uk** |
| **--------------------FOR USE BY GLOUCESTER HOUSE STAFF --------------------** |
| Referral received date: |  | Date of Acceptance: |  |
| Accepted by (Clinician):  |  | Start Date: |  |