Referral Form

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | |
| Is the young person a dependant of a current or former member of the British Armed Forces: | | | | | YES  NO | | | |  | | | | | | | | | |  | | |
| 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 Numbers  Mobile  Home | | | | | | | | | |  | | |
| Full Name: | | | | |  | | | | Relationship: | | | | | | | | | |  | | |
| Address: | | | | |  | | | | Contact Numbers  Mobile  Home | | | | | | | | | |  | | |
| Full Name: | | | | |  | | | | Relationship: | | | | | | | | | |  | | |
| Address: | | | | |  | | | | Contact Numbers  Mobile  Home | | | | | | | | | |  | | |
| 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 or  Part 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**](mailto:Gloucesterhouseadmin@tavi-port.nhs.uk) | | | | | | | | | | | | | | | | | | | | | |
| **--------------------FOR USE BY GLOUCESTER HOUSE STAFF --------------------** | | | | | | | | | | | | | | | | | | | | | |
| Referral received date: | | |  | | | | | Date of Acceptance: | | | | |  | | | | | | | | |
| Accepted by (Clinician): | | |  | | | | | Start Date: | | | | |  | | | | | | | | |