Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

CYPIT Children and Young People's Integrated Therapies Service

REFERRAL FORM

Speech and Language Therapy, Occupational Therapy, Physiotherapy and Dietetics Services for Children and Young People

Patient's name:	NHS No:
D.O.B:	Referrer's Name / Address / Telephone number:
Male/Female:	Referrer's relationship to child / young person:
Previous/Other names, (if applicable):	Has Parent / Guardian consented to this referral? YES / NO Referrals can only be accepted if parental consent has been given. However, you can ring the BHFT SPE Hub for advice on how to help if there is no parental consent on **0844 406 0979**
Address:	
Email Address/ Are you happy for us to contact you and/or send you information regarding your child i.e. appointments or reports etc. by email? YES/NO	
Does the patient live alone (if a young person?)	Patient ethnicity:
Nursery/School name and location:	
Child/young person's main language:	

How are you hoping we can help? Please explain the **impact** of this problem on the child/young person's daily life What have you previously tried and what impact did this have?
Does the child/young person have a Statement of Special Educational Needs or an Education Health & Care Plan: Yes / No / In Progress Is an interpreter required for parental discussion: Yes/No/Don't know If Yes what language, (including signing):

Is an interpreter required for child's assessment: YES/NO/Don't know
If yes what Language , (including signing):

Are you able to read information if I send it to you? YES/NO/Don't Know

Does the child have any allergies: YES/NO
If yes please specify:

Has the child had a hearing test: YES/NO
What date: Where:
Results

Has the child had a vision test: YES/NO
What date: Where:
Results:

Has the child/young person received a diagnosis(es): YES/NO

If YES please specify.

Current Medications:

For Dietetics Referrals ONLY accepted from a Paediatrician or BHFT community dietetics services:
Patient's weight:
Patient's Height:
Change in weight in centiles over the last 6 months

Is the referral "Urgent" because of recent or planned surgery? YES/NO
Please give details and dates:

Referral concerns are about difficulties with swallowing, eating and drinking: YES/NO
Is the referral for a Dietician from a Paediatrician, (Acute or Community) about children/young person who is tube fed and/or losing weight? YES/NO

If YES to any of the above send to CYPIT that day, marked urgent.

DEVELOPMENTAL INFORMATION Can the child/when did the child first:

Roll over:

Sit independently:

Crawl:

Walk:

Stand independently:

Babble:

Use his/her first words:

Put words together:

PLEASE FILL IN SECTIONS BELOW THAT ARE RELEVANT **ONLY** TO YOUR CURRENT CONCERNS AND REASON FOR REFERRAL:

Information about Speech, Language and Communication needs:				
	Finds Difficult	Can do with support	Can do well	Comments
Attention, Listening & concentration				
Can understand spoken instructions and information				
Can use words and sentences to express himself/herself.				
Uses speech sounds clearly,(is it easy to understand the child's speech production?	Only familiar adults can understand child's speech	Some less people can understand child's speech	Everyone can understand child's speech	
Does the child use a dummy? YES / NO				
Information about Behaviours:				
	Finds Difficult	Can do with support	Can do well	Comments
Plays and engages well with other children				
Sitting still during a task				
Can tolerate change in their routine				
Will try new foods				
Information about independence skills:				
	Finds Difficult	Can do with support	Can do well	Comments
Dressing and undressing, (including fastenings)				
Getting to sleep				
Using cutlery				
Washing and drying face, hands and body				
Going to the toilet				

Information about Physical skills:				
	Finds Difficult	Can do with support	Can do well	Comments
Walking & running				
Balance including jumping and hopping				
Riding a bike				
Swimming				
Ball skills – throwing and catching				

Information about Foundation and Classroom Skills:				
	Finds Difficult	Can do with support	Can do well	Comments
Drawing & writing				
Using scissors				
Following Instructions				
Organisation				
Willingness to take part in activities directed by others				

He/she avoids certain activities (more than other children of their age):
Please give an example:

He/she seeks certain activities (more than other children of their age):
Please give an example:

He/she has participated in additional targeted activities and support at school to promote specific areas of learning and development.
Please give details:

Any other comments related to the child's/young person's needs:

We might contact you in the future to discuss the service you have received from CYPIT. Are you happy for us to do this?	YES/NO

Return Address:
Berkshire Healthcare Foundation Trust
Single Point of Entry Hub
The Old Forge, 45-47 Peach Street
Wokingham, Berkshire
RG40 1XJ

Email: Bks-tr.healthhub@nhs.net
Phone: **0300 365 1234**