**CHILDREN’S LEARNING DISABILITY NURSING TEAM REFERRAL FORM**

(INADEQUATELY COMPLETED FORMS WILL BE RETURNED TO THE REFERRER)

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| **\* CHILD / YOUNG PERSON’S DETAILS:** | **Referral Date: / /**  |
| **Name:**  |   | **Date of Birth:** |  | **Age:** |  |
| **Is the child/young person known by any other surname?**  **No** If yes, please specify:  |
| **NHS Number:** |  | **Gender: Female** |  | **Ethnicity:** |  |
| **Usual Address:** |  | **Tel No:**  |  |
| **Mobile. No:** |  |
| **Email address:**  |
| Tick if the appointment needs to be made by telephone (e.g. for literacy reasons) |
| **GP Name and Address:** |  | **School/Nursery/ College:** |  |
| **Tel:** |  | **Tel:** |  |
| **Does the child / young person have a learning disability?**  |  **Yes  No**  |
| **Is the child / young person going through the Autism Assessment Process and is under 11?** |  **Yes  No**  |
| **Does the child / young person have a diagnosis of Autism and is under 11?** |  **Yes  No**  |
| **Identified Physical Health Problem?**If yes, please give details:  |  **Yes  No**  |
| **Has the child / young person been referred previously to the Children’s Health Services?** If yes, which service, when and with what outcome?  |  **Yes  No**  |
| **Has an Early Help form been initiated (please attach)**  |  **Yes  No**  **Unknown**  |
| **Does the child / young person have an Education, Health and Care Plan? Yes**  **No**  **Unknown**  |
| **Are there any safeguarding issues? Yes**  **No**   **Unknown**  |
| **Does the child / young person have an open referral with CAMHS?** **No Yes**  **No**   |
| **Interpreter required Yes**  **No**  |
| **British Sign Language required Yes**  **No**  |
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| **\* PARENT / CARER DETAILS:** |
| **Full Name(s) of Parent(s) / Guardian(s):** | **Parental Responsibility held by:** |
| **1) First Name:**  | **Surname:**  |  | **Yes  No**  |
| **2) First Name:**  | **Surname:**  | **Yes  No**  |
| **Who is the child living with?** |  |
| **Siblings names and ages:** |  |
| **Permission to leave a message?**  |  **Yes  No**  |
| **Do any of the parents / carers have learning difficulties? Yes  No**  |
| **Has the child/young person given consent for the referral? Yes**  **No**  If no, please state reason: |
| **Has the parent given consent for the referral? Yes**  **No** If no, please state reason: *(Please note that we are unable to see children without agreement)* |
| **Has the parent given consent for the service to access child’s record to gain information about diagnosis appropriate to the referral? Yes  No** If no, please state reason: yes (Please note that we are unable to accept referrals without gathering information about diagnosis) |

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| **\* REFERRER DETAILS:** |
| **Referrer’s Name:** |  | **Profession:** |  |
| **Address:** |

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| **Tel. No:** |   | **Signature of Professional:** |  |

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| **Has the Child/Young Person been seen by you as a Referrer?** |
|  **Yes  No**  |

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| **REASONS FOR REQUEST (please continue in additional information section below, if necessary):****Include Diagnosis (if applicable)** |
| **Please clearly identify the reason the referral, including the child’s / young person’s difficulties and abilities, and the impact this has on his/her life:**  |
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| **What has been previously tried and what was the outcome e.g. Services or Intervention? Action or Advice given?** |
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| **Background/Family History/Social Circumstances:** |
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| **Past History of problems:** |

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| **Identified Risk:***Please inform us of any known risks in relation to the child/young person being a risk to themselves or others; any risk to child/young person from others (e.g. sexual exploitation, sexual abuse, physical abuse) or any risk that may potentially occur to staff whilst working with this child/young person or family.* |
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| **What are your expected outcomes of this referral?** |

**PLEASE ATTACH ANY RELEVANT DOCUMENTATION**

**(e.g. early help assessment form, etc)**

**Please send to:** **CumbriaChildrensLD@CNTW.nhs.uk**

**Carlisle Office**

**Springboard Child Development Centre**

**Orton Road**

**Carlisle**

**CA2 7HE**

**Tel: 01228 603195**

**Workington Office**

**Unit 9**

**Lillyhall Business Centre**

**Jubilee Road**

**Workington**

**Cumbria**

**CA14 4HA**

**Tel: 01900 705081**

**Children’s Learning Disabilities Nursing Team**

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| **Office Use:** |
| **Date Received:** |  | **Date Entered Onto RiO:** |  |