St Helens and Knowsley Teaching Hospitals NHS Trust

REFERRAL FORM FOR DEVELOPMENTAL PAEDIATRICS

Referrals will be accepted from: SENCO's, GPs, Consultants, Hospital clinicians, CAMHS professionals, Educational Psychologists, Specialist nursing professionals, Health Visitors, School Nurses and Allied Health Professionals

PLEASE COMPLETE ALL SECTIONS IN FULL OR THE REFERRAL MAY BE RETURNED

LIST OTHER PROFESSIONALS INVOLVED (PROVIDE NAME IF KNOWN)			
	Name of Professional:		**Name of Professional:**
Audiology/ENT ☐		**CAMHS** ☐	
Other Consultant ☐		**Health Visitor/School Nurse** ☐	
Speech and Language Therapist ☐		**LA Vision / Hearing Team** ☐	
Occupational Therapist ☐		**Social Worker** ☐	
Physiotherapist ☐		**Weight management** ☐	

Educational Psychologist ☐		Physiotherapist ☐	
FNP ☐		Continence Service ☐	
SOCIAL CARE STATUS (IF APPLICABLE)			
Child Protection Plan ☐	Looked after child ☐	Child in Need ☐	EHAT ☐

CHILD/ YOUNG PERSON DETAILS:	
Name:	
NHS number:	
D.O.B:	
Gender:	
Ethnic Category:	
Address:	
Preferred Tel No:	
Name of Parent Guardian with legal parental responsibility:	
G.P (name and address):	
First Language:	
Interpreter needed: Y/N	
Early Years Setting/School:	

REFERRER DETAILS AND CONSENT:	
Referrer's Name:	
Role:	
Contact Address:	
Contact telephone number:	
Referrer's Signature:	
Date referral completed:	
I confirm that this child has not been referred to another service / agency for the same condition (please tick) ☐	
<u>Parental Consent Obtained:</u> **Verbal consent if a health professional** ☐ **Written parental consent form completed and attached if not health professional** ☐	

Does the child/young person have a diagnosed medical condition that requires further assessment?	**YES / NO**
Details: *(Please explain how these difficulties are affecting the child/young person at home, school, in public venues with specific examples)*	
Does the child/young person have significant difficulty with attention, impulsivity and	**YES / NO**

hyperactivity which impact on learning/ behaviour and requires further assessment? **N.B. Developmental Paediatrics does not accept referrals for ADHD investigation for patients under the age of 5 years 6 months.** (please attach current academic and behavioural reports to evidence concerns)	
Details: *(Please explain how these difficulties are affecting the child/young person at home, school, in public venues with specific examples)*	
Are there significant concerns about the level of physical or social development or loss of skills already acquired?	**YES / NO**
Details: *(Please explain how these difficulties are affecting the child/young person at home, school, in public venues with specific examples)*	
Does the child/young person have a diagnosis of a neurodevelopmental condition and sleep issues? **N.B. Developmental Paediatrics does not accept referrals for sleep issues for patients without a current diagnosis of a neurodevelopmental condition.**	**YES / NO** **If yes, please fill out the sleep checklist form attached.**
Is the child/young person currently taking any medication?	**YES / NO**
Details:	
What strategies or techniques have you tried to overcome these difficulties and how long were they in place before this referral was made? *(please attach any other relevant assessment information or recorded observations when you send in this referral)*	
What was the result of the strategies / techniques put in place?	

Is this child known to the SENCO at their school and have they used a graduated response?	**YES / NO**
Details:	
Has this child/young person been discussed at a school consultation meeting attended by a multi-disciplinary team and the family? If so, please provide details of the outcomes from this meeting with the referral.	**YES / NO**
Details:	
Has the School Nursing Team or Health Visitor provided any support to the child/young person? If so, please provide details of this with the referral.	**YES / NO**
Details:	
Does this child/young person have an Individual Education Plan or IBP in place? If so, please provide details of this with the referral, including if this child/young person is currently home schooled.	**YES / NO**
Details:	
If the child/young person has an EHCP, when was this last reviewed to ensure the plan is adequate to support the individual needs of the child/young person?	**YES / NO**
Details:	
Has the St Helens Local Offer been reviewed for potential support for the child/young person's specific needs? If not, please access this directory of support and services via https://www.sthelens.gov.uk/schools-education/sen-the-local-offer/ ?	**YES / NO**
Details:	

Have you accessed the Behaviour Improvement Team (BIT) for advice/consultation/assessment for the child/young person if they are in reception, KS1 or KS2? If not, please consider the support of BIT if behavioural difficulties are affecting their wellbeing and/or education more information can be found here http://paceandlaunchpad.sthelens.gov.uk/sections/outreach-support/	**YES / NO**
Details:	
Have the family been recommended or offered any specific parenting courses to support with a child's specific needs or behaviours, such as Positive Parenting Programme (PPP)? If not, please visit https://www.sthelens.gov.uk/media/2033/1401122-parenting-team-leaflet-low-res.pdf for further information on how this can support the family.	**YES / NO**
Details:	
Please tell us what you hope to gain from referral to Developmental Paediatric s? **Parents (please provide any supporting information that you feel is relevant):** **School/ Early years setting:**	

PARENT / CARER CONSENT FORM FOR REFERRAL

(*Please note written consent must be obtained from the parent/carer with parental responsibility for the child)*

- I give consent for my child to be referred to the Developmental Paediatrics.
- I give consent for St Helen's and Knowsley Teaching Hospitals staff to liaise and consult with other people involved with my child
- I give consent for the St Helen's and Knowsley Teaching Hospitals staff to share information with other services involved with my child
- I confirm that I have not been referred elsewhere for this same problem

Parent / Carer Name

(Print)……

Signature……

Date ……

SLEEP CHECKLIST

PLEASE COMPLETE ALL SECTIONS IN FULL

Services Accessed:	Yes	No	Details:
St Helens 0-19 HCP services			
Homestart St Helens: Volunteer support			

School Readiness Project			
ADDvanced Solutions: **Community Network Group** **Family Learning Programme**			
St Helens Children's Centres: **Day care** **Infant Bonding** **Play in the Home** **New beginnings** **Baby Groups** **Nurture Pathway**			
The Sleep Charity			
The Children's Sleep Charity			
Alder Hey – Sleep support service			
GP			
Health Visitor			
Strategies Implemented:	**Yes**	**No**	**Details:**
Visual timetables: **AM** **PM**			
Fine motor skills before bedtime: **Puzzles** **Reading** **Drawing** **Jigsaw** **Play dough**			
Outdoor physical activities **Groups** **Sports**			
Reducing amount of time accessed on: **IPAD** **Phones** **Computer** **X-Box** **Play Station** **Removing equipment**			
Gro Clock			
Bedtime pass			
Relaxing bath time			
Warm milky drink			
Lavender **sleep spray** **pillow spray**			
Sleepy foods : **Almonds** **Bananas** **Oatmeal**			

Cherries /Cherry juice Cereal Dairy: Yogurt, milk, cheese			
Creating a calm bedroom			
Listening to music white noise			
Consistent routines at bedtime			
Massage			
Weighted blankets			
Sleep socks			
Disappearing Chair Routine			
Reward chart			
Sleep diaries			
Identifying outside distractions: Road noise Lights/lamp posts Neighbours Animals			
Social Stories			
Late sleeping phase			
Moving bedtime backwards: Phase advancement			
Changing lighting in the bedroom: Blue, green, brown			
Daytime sleeping: Reducing daytime naps Stopping daytime naps			
Establish waking time, routine			
The coping tool box			
SMART goals			