**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? Yes**  **No** If yes, please specify:  |
| **NHS Number:**  |  | **Gender:** |  | **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 & 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? 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:**  |  |
| **2) First Name:**  | **Surname:**  |  |
| **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: Only spoke to parent |
| **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)* |

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| **\* REFERRER DETAILS: Parents – as above** |
| **Referrer’s Name:** |  | **Profession:** |  |
| **Address:** |  |
| **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):** |
| **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:**  |
| **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:** |
| **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 my potentially occur to staff whilst working with this child/young person or family.* |
| **What are your expected outcomes of this referral?** |

**PLEASE ATTACH ANY RELEVANT DOCUMENTATION**

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

**Please send to:**

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| **FOR NORTH CUMBRIA** | **FOR SOUTH CUMBRIA** |
| **Carlisle Office** **Springboard Child Development Centre****Orton Road****Carlisle****CA2 7HE** **Tel: 01228 603195****Workington Office****Workington Community Hospital****Park Lane****Workington****CA14 2RW****Tel: 01900 705081** | **Barrow-in Furness Office****College House****Howard Street****Barrow-in-Furness****LA14 1NB****Tel: 01229 404693** |
|  | CumbriaChildrensLD@lancashirecare.nhs.uk |

**Children’s Learning Disabilities Nursing Team**

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