**INTEGRATED CHILDRENS THERAPY TEAM REFERRAL FORM**

**Occupational Therapy** [ ]  **Physiotherapy** [ ]  **Dietetics** [ ]

**For SPEECH AND LANGUAGE THERAPY, please contact the request for help line on 01904 726599 (York/Selby) or 01723 342472/01904 726410 (Scarborough/Whitby/Ryedale)**

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| **Is this a re-referral?** Yes [ ]  No [ ]  Don’t know [ ]  |
| Child’s name: Known As:      NHS No: Pronouns: He/She/They/Other:      Date of Birth: Male [ ]  Female [ ]  Intersex [ ]  Non-binary[ ]  Own Term:                       Prefer Not To Say [ ]  | Address: Telephone No: Email address:  |
| School/Nursery: Name of Parent/Carer(s): Relationship to child: Who has parental responsibility?  |
| Are there any Safeguarding concerns?Is the child subject to a looked after child review?  |  Yes [ ]  No [ ]  Yes [ ]  No [ ]  |
| If yes, please give further details (include social worker/family support worker details): ***If circumstances change following this referral please let the relevant Therapy Team know*** |
| GP details: Paediatrician:  Other professionals involved:   |
| ***This section is only to be completed for a referral to MSK Physiotherapy*****What is the reason for this referral?**  **Location of pain:**  **Duration of pain:**  **Impact on activities of daily living:**   |
| ***For all other referrals:*****What is the reason for this referral?**  **Level of concern: Family:** Low [ ]  / Medium [ ]  / High [ ]  **Referral Agent:** Low [ ]  / High [ ] **Child/Young person:** Low [ ]  / High [ ]  / Not applicable [ ]  |
| **What do you want help with from Children’s Therapy Services?** (please consider what the younger person, parents and school may also want help with) **How are the difficulties affecting the child’s everyday life at home and at nursery/school:** **Self-management strategies/advice already tried and the outcome (if known):**   |
| **Relevant medical history (medication, weight, height where appropriate) and medical diagnosis:**  *Please attach recent clinic report if available* |
| **Does the Child/young person have an Education Health and Care Plan in place?**Yes [ ]  No [ ]  |
| **Are the child’s abilities (e.g. physical skills; communication skills; learning level):**[ ]  all at the same level, or[ ]  Is one area of development significantly lower than the others? Please state which ability is lower: [ ]  I don’t know |
| Is an interpreter or signer required? YES [ ]  NO [ ]  Language and service required: Can parents/carers understand written information? YES [ ]  NO [ ]  |
| Has the parent/carer person been informed and given their consent for this referral?[ ]  YES [ ]  NOFor secondary school aged children, has the young person been informed of this referral and the reason for it? [ ]  YES [ ]  NO |

Please make sure all parts of the form are completed.

Decisions regarding the acceptance of referrals are based on information supplied. Incomplete forms will be sent back to the referrer for completion prior to the referral being processed.

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| Signed Referrer:  | Designation/Role:  |
| PRINT Name:  | Date:  |
| Address:  | Telephone Number:  |

**Please email completed referral forms to:** **yhs-tr.ChildrenTherapyAdmin@nhs.net**

 **For DIETETICS referrals, please send to:** **yhs-tr.yorkdietitians@nhs.net**

**Or send by post to:**

**York & Selby Area**

Children’s Therapy Team, Child Development Centre, York Hospital

Wigginton Road, York, YO31 8HE.

**Scarborough Whitby Ryedale Area**

Children’s Therapy Team, Springhill House, Springhill Close, Scarborough, YO12 4AD