

Which service do you require?
 (Please select)

- Occupational Therapy Paediatrician
 Physiotherapy Enuresis
 Speech & Language Therapy (Bedwetting) clinic

For office use only:

Details of child / young person (please fill in all details)

Surname		Date of birth	Male / Female	
Forenames		Ethnicity	NHS No.	
Also known as		GP details & borough (if not Newham)		
Address		Parent / carer names		
Postcode		Home Language		
Telephone No.		Interpreter required for	Parent /	Child / neither
School	Year Class	Health Visitor / School Nurse		

Are there any current or previous safeguarding issues for the child / young person / family? Yes / No / Not sure

Reason for referral (please fill in all details)

Medical Information (please fill in all details)

Diagnosis (if known)

Hearing / vision needs (most recent results)

Other professionals the child/young person is known to in the Community or Hospital (please provide details)

How are child's / young person's difficulties impacting on their everyday life?

Movement and mobility: (e.g. sitting, standing, walking, balancing and co-ordination)

Self-care tasks: (e.g. dressing, bathing, eating and drinking, organising self, independence)

School tasks: (e.g. writing, using scissors, participation in PE, maintaining attention)

General development, cognition and learning skills: (e.g. developmental milestones, nursery/school academic performance, learning, sleep, behaviour including sensory behaviours)

Play skills: (e.g. interest in toys, turn-taking, playing with peers, role play and imagination)

Communication and attention: (e.g. understanding spoken language, putting sentences together, social communication, unclear speech, stammer)

Eating, Drinking and Swallowing (please select all that are relevant)

- Child has signs of difficulty when eating/drinking e.g. coughing / gagging / flushed cheeks / watery eyes / wet gurgly voice or breath
- Child has repeated chest infections
- Faltering growth/failure to thrive
- Oro-motor difficulties impacting on chewing/manipulating food in the mouth
- Does the child need the textures altering?
- Have there been changes in the child's feeding skills?
- Any difficulties sucking e.g. breast/bottle feeding?

Additional comments:

Contenance (please select all that are relevant)

- Child / young person has not achieved continence
- Child / young person has restarted bedwetting
- Child / young person has constipation / soiling / encopresis

Additional comments:

Details of person making the referral

Name (print)	Signature	Referral Date
Job Title	Base	Tel. No

Consent

Has the parent / carer given their consent for this referral? Yes / No (circle)

When a referral is made, written permission MUST be obtained from the child's/young person's parent/carer, as:

1. Referrals may be discussed in a Multiagency meeting including Health, Education, Children's Centres and Social Services.
2. The child/young person may be seen by a Therapist either in a Community clinic (with the parent / carer present) but also in a School clinic (without the parent / carer present).

I confirm that I have parental responsibility for the child/young person being referred, and give permission for my child to be seen by the relevant health professionals.

Name of Parent / Carer (print)

Signed

Relationship to child

Date

Please return completed form and any relevant reports to:
CDS & Therapies Triage, West Ham Lane Health Centre, 84 West Ham Lane, Stratford, London E15 4PT

Referrals should be emailed securely to newhamcads@nhs.net either using nhs.net email addresses or via other secure domains such as gcsx.gov.uk or egress secure email