

**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 <input type="checkbox"/> / Female <input type="checkbox"/> |
| 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 <input type="checkbox"/> Parent <input type="checkbox"/> Child / neither <input type="checkbox"/> |   |
| School   | Year Class | Health Visitor / School Nurse  |   |
| Are there any current or previous safeguarding issues for the child / young person / family?    Yes <input type="checkbox"/> / No <input type="checkbox"/> / Not sure <input type="checkbox"/> |            |  |   |

**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 ()

**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](mailto:newhamcads@nhs.net) either using nhs.net email addresses or via other secure domains such as [gcsx.gov.uk](mailto:gcsx.gov.uk) or egress secure email**