**REDBRIDGE SINGLE POINT OF ACCESS REFERRAL FORM - Specialist Community Health Services for Children and Young People,**

**Telephone**

020 8708 3885

**E-mail**

cpat.referrals@redbridge.gov.uk

**Website**

[https://www.redbridge.gov.uk/](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.com%2Fv3%2F__https%3A%2Fwww.redbridge.gov.uk%2Fadult-and-childrens-services%2Fchild-protection%2F__%3B!!ASwD9k8!KrC96CSpFAtoQBPF6PeoWMr-ZHNZrQByLqnsJMLT73KOpBE5BZEEsT1fT9Nyi78TUfcWE2KXtHNvNbtKfa8Ok6o6caK_hmDrBM8nouI%24&data=05%7C02%7CNicola.Wolf%40redbridge.gov.uk%7C4ba1bc6341714b73609c08dca1a62139%7C2a8b2c162e9e4dcea97ba0b34e803a22%7C0%7C0%7C638562982094134505%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=6Bbe4MOADqxkXgPIxfePVgP2o8Rmo0s2VmqPsKd3OtE%3D&reserved=0)

**Address**

Redbridge Multi Agency Safeguarding Hub (MASH), Lynton House, 255-259
High Road
Ilford
Essex

IG1 1NY

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| --- | --- |
| **Section 1** | Person Making Referral: |
| Name: |       | Address       |
| Job Title: |       |
| Telephone:  |       |
| Email: |       |
| **Section 2** | **Area of Practice the referral is coming from:** |
| [ ]  | Parent / Guardian | [ ]  | CWD | [ ]  | The Grove (add specialism) |
| [ ]  | Astrum School OT | [ ]  | GP | [ ]  | Hospital |
| [ ]  | Hospice | [ ]  | CAMHS | [ ]  | School / SENCo |
| [ ]  | Social Worker | [ ]  | Nursery | [ ]  | Educational Psychologist |
| **Section 3** | Child / Young Person’s Details |
| Child/Young Person Full Name:        | Date of Birth       |
| Preferred Name/Known as       | Pronouns       |
| Address:        | Gender        |
| NHS Number:       |
| Name of School / Nursery / College      |
| Parent/Carer Mobile        | Language       |
| Child’s Mobile       | Interpreter required: [ ]  Yes [ ]  NoWhich language       |
| Home Telephone:       |
| **THIS QUESTION MUST BE COMPLETED.** Does the patient wish to receive information electronically from LBR, to a personal /unsecure email address?   [ ]  Yes [ ]  NoEmail Address:  | Religion:       |
| Ethnicity       |
| Nationality       |
| Subject to Child Protection Plan / Child In Need: Y [ ]  N [ ]  |
| GP Address / Surgery       |
|   | LAC Status:       |
| Social Services Protocol No.       |
| **Section 4** | **Parent or Carer’s Details** |
| Who has parental responsibility?       | Interpreter required: [ ]  Yes [ ]  No |
| Parent / Carer’s Name:       | Relationship:       |
| Address:        | Telephone:       |
| Mobile:       |
| Assistance required [ ]  Yes [ ]  No | Email Address       |
| [ ]  | **Reason for referral and explanation of concerns including specific functional, sensory, motor difficulties, health, mental health or social needs or any identified risks (Please attach relevant reports e.g. school), if known and any other interventions already tried:** |
| [ ]  |
| [ ]  | **Medical Information (i.e. birth history, current health issues, medication, admission/discharge details, allergies, feeding related coughing, choking, vomiting, chest infection), if known. Attach relevant medical / other reports:** |
| [ ]  |
| Height: |       | Weight: |       | BP: |       | Pulse: |  |
| **Section 5** | **Name of other Professionals / Agencies involved, if known:** |
| [ ]  | Social Worker | [ ]  | Nursery | [ ]  | Educational Psychologist |
| [ ]  | Court | [ ]  | Police | [ ]  | Educational Welfare Officer |
| [ ]  | Health Visitor | [ ]  | SENCo | [ ]  | Hospital/Community Doctor |
| [ ]  | EWMHS | [ ]  | Youth Offending Service | [ ]  | Children With Disabilities Team |
| [ ]  | Early Intervention | [ ]  | Child Development Team | [ ]  | Other (specify) |
| Any other comments on other involved services |
| **Section 6** |
|  | **Developmental History and Milestones:** |
|  | Age of walking  | Age of sitting: | Date of Hearing Test: |       |
|  | Age of Smiling  | Age of first words: | Date of Eye Test: |       |
| **Section 7** | **Parent’s/Carer’s concerns and expectations / History of difficulties (date of onset, are the symptoms stable or worsening, what was tried/what has worked so far) / Impact of the difficulties on the young person and family:** |
|   |
| **Section 8** | **Family History (including family composition, support network, others with illness or disability in the family, family history of mental health / substance misuse) and if other siblings are known to child health services:** |
|  |
| **Section 9** | Consent  |
| **PLEASE COMPLETE THIS SECTION IN FULL.**Information about your child may be shared with other teams and agencies (eg Education services, Children’s Centres and social care) in order to identify the most appropriate support for your child.Has the referral been discussed with the parent or carer? **[ ]  Yes [ ]  No**Has the referral been discussed with the child or young person? **[ ]  Yes [ ]  No**Is there parental consent for enquiry/onward referral to other agencies? **[ ]  Yes [ ]  No****Comments (if any): ………………………………………………………………………………………………………………………..****Signed (Parent/Carer)       Relationship:       Date:****Signed (referrer):** **Name:** **Date:** |
|  |  |