



Multi Agency Team Referral Form The Children's Centre, Neath Port Talbot Hospital

IMPORTANT: Please read before completing:

- The Multi Agency Team is made up of professionals from the following services:
Community Paediatrics, Physiotherapy, Occupational Therapy, Speech and Language Therapy, Dietetics, Flying Start Educational Psychology, Social Services Child Care Disability Team, Specialist Health Visiting, Action for Children Behaviour Support.
- This referral pathway is for children and young people aged 0-18 years, where there are concerns about their development and they may require assessment by **two or more** professionals from the above Multi Agency Team.
- MAT Referral meetings are held weekly on a Wednesday morning. The cut-off point for the receipt of referrals is 12 noon the previous Friday. An outcome letter will be sent to the parent/ carer (unless an alternative method of communication is specified); referrers will receive a copy of outcome letter.
- Please note: If the child or young person only needs assessment by **one** professional, then a single referral should be sent directly to that service.

The information you give on this form will be discussed with members of the Multi Agency Team (as above) in order to ensure the most appropriate and timely assessment.

Please make sure you have the consent of the person with parental responsibility before completing this referral.

- Please give as many details of the child's difficulties as possible.
- ALL** relevant parts of this referral **MUST** be completed.
- Incomplete referrals will be returned resulting in an unnecessary delay to assessment.
- Please enclose any supporting evidence e.g. MCHAT, SOGS
- Info for Schools only:**

Any school referral for Speech and Language Therapy needs to be made on the Communication and Support Forum Referral Form.

Return your fully completed form to:

Children with Disabilities Co-ordinator
The Multi Agency Team,
Children's Centre,
Neath Port Talbot Hospital,
Baglan Way,
Neath Port Talbot
SA12 7BX

☎ 01639 862713

💻 www.abm.wales.nhs.uk/childrensdevelopment

Referrer’s details:

By completing the following section you are confirming that the parent or guardian has received a Multi Agency Team leaflet or has had the service explained to them. You are also confirming that the parent or guardian is aware that their child or young person may be discussed and assessed by one or more of the Multi Agency Team and they have given their signed or verbal **consent** for that to happen.

Please state if there is someone the child or young person should not be discussed with:

Name of Referrer:	Parental/Guardian Consent: Signature of Parent/Guardian:
Role:	Please print name:
Address:	Place X in box if verbal consent given: <input type="checkbox"/> By checking this box you are verifying that consent has been given by a person with parental responsibility.
Telephone number:	
Signature of referrer:	Please select parent / guardian’s preferred method of communication:
Date of referral:	Written / Verbal / To be contacted by referrer Other:

Child or young person’s details:

Name:	Address:	
Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Postcode:	
Hospital Number: NHS Number:	Telephone number of parent/carer:	
Date of Birth: Age:	GP Name & Address:	
Parents/Carers Name:		
Name of School/Playgroup:	Health Visitor Name & Address:	
Does the child live in a Flying Start area : Y / N		
Language spoken at home:	Consultant name:	
Is an interpreter/signer required: Y / N	Diagnosis (if applicable):	
State language if applicable:	Disabled: Y / N	On Disability Register: Y / N

Family Structure / Family Tree :

Genogram

Family History :

- | | |
|--|--|
| Mental Health <input type="checkbox"/> | Physical Illness <input type="checkbox"/> |
| Learning Disability <input type="checkbox"/> | Domestic Violence <input type="checkbox"/> |
| Substance Misuse <input type="checkbox"/> | Alcohol Misuse <input type="checkbox"/> |

Referral details:

Please tick which professionals you think this child needs:

(if completing electronically, double click in box and select 'checked').

- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy (0-4 years only)
- Community Paediatricians (professional referral only)
- Dietetics
- Flying Start Educational Psychology (24 - 36 months only)
- Social Services Child Disability Team
- Specialist Health Visiting
- Behaviour Support

Please provide as much information as possible to support your referral:

What are your main concerns/ reasons for this request?

What has worked well?

What have you tried that has not worked well?

Health (including medication/ investigations, equipment etc):

Education:

Emotional and behavioural development:

Self care skills:

Social circumstances (e.g. housing, etc):

Any other relevant information:

Views of child or young person and parent/ carer regarding this referral:

All agencies currently involved, please state:

Social Services	<input type="checkbox"/>	Social Worker's name: _____			
Paediatrician	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	Educational Psychologist	<input type="checkbox"/>
Specialist H/V	<input type="checkbox"/>	Physiotherapy	<input type="checkbox"/>	Facing the Challenge	<input type="checkbox"/>
Neurology	<input type="checkbox"/>	Speech & Language	<input type="checkbox"/>	Action for Children	<input type="checkbox"/>
Audiology	<input type="checkbox"/>	Orthotics	<input type="checkbox"/>	Team around the Family	<input type="checkbox"/>
Dietetics	<input type="checkbox"/>	Orthopaedics	<input type="checkbox"/>	Portage	<input type="checkbox"/>

Other (please state):

	Yes	No
Is the child/ young person on the Child Protection Register?	<input type="checkbox"/>	<input type="checkbox"/>
Is the child/ young person a 'child in need'?	<input type="checkbox"/>	<input type="checkbox"/>
Is the child/ young person a 'looked after child'?	<input type="checkbox"/>	<input type="checkbox"/>

(To be detached from referral by CWD Co-ordinator)

FURTHER DETAILS ABOUT CHILD/ YOUNG PERSON

The following details are requested for the purpose of equalities monitoring only.

This information is reported anonymously.

Gender:

Age:

Disability:				
No diagnosis Physical development Learning Communication Sensory Complex needs				
Child/ Young Person's Ethnicity:				
White	Mixed	Asian	Black	Other Ethnicity
British <input type="checkbox"/>	White & Black	Indian <input type="checkbox"/>	African <input type="checkbox"/>	Chinese <input type="checkbox"/>
Irish <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Any other background <input type="checkbox"/>
Other <input type="checkbox"/>	White & Black African <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Any other Black background <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>
	White & Asian <input type="checkbox"/>	Any other Asian background <input type="checkbox"/>		If other, please specify.....
	Any other mixed background <input type="checkbox"/>			
Child/ Young Person's Religion/ Belief:				
Christian <input type="checkbox"/>	Hindu <input type="checkbox"/>	Jewish <input type="checkbox"/>	No religion <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>
Muslim <input type="checkbox"/>	Sikh <input type="checkbox"/>	Buddhist <input type="checkbox"/>	Any other religion <input type="checkbox"/>	
Child/ Young Person's Nationality (if not British):				
Nationality:		Home Office Registration Number:		
Immigration Status:		Asylum seeking/ Refugee status/ Exceptional Leave		
Welsh Language:				
Fluent speaker & writer <input type="checkbox"/>	Fluent speaker <input type="checkbox"/>	Learner <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>	
Fairly fluent & writer <input type="checkbox"/>	Fairly fluent speaker <input type="checkbox"/>	Little or no knowledge <input type="checkbox"/>		
Gender Reassignment:				
The same as at birth <input type="checkbox"/>	Not the same as at birth <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>		