GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Information for completing the Referral Form:
Children's Clinic, Singleton Hospital

This referral form is for referring Children and Young People to The Multi Development Team(MDT)**, which includes**:

- Dietetics (0-19 years)
- Occupational Therapy (0-19 years)
- Paediatricians
- Physiotherapy (0-19 years)
- Speech and Language Therapy (0-4 years only)

- **Please give as many details of the child's difficulties as possible**

- **Please ensure you have parents consent and make the parents aware that the child may be assessed by one or more of the Multi Disciplinary Team (MDT)**

- ***Info for Schools only:*** **Any school referral for Speech and Language Therapy needs to be made on the Communication Forum Referral Form**

- ***Info for School age children only:*** **Any referral for the Community Paediatrician needs to be completed on the School Doctor Referral Form**

Return the Referral form to:

The MDT Referral Team,
Hafan y Mor
Singleton Hospital,
Sketty
Swansea
SA2 8QA
Telephone: 01792 200400

www.abm.wales.nhs.uk/childrensdevelopment

IMPORTANT – PLEASE READ BELOW BEFORE COMPLETING THIS FORM

ALL *relevant parts of this referral* ***MUST*** *be completed. Incomplete referrals will be returned resulting in an unnecessary delay to assessment.*
It is our usual practice to discuss the information on this form with members of the Multi Disciplinary Team in order to ensure the most appropriate and timely assessment

Please tick which discipline/s you feel the child needs:

PHYSIOTHERAPY ☐ ***OCCUPATIONAL THERAPY*** ☐ ***SPEECH & LANGUAGE*** ☐ ***DIETETICS*** ☐ ***PAEDIATRICIANS*** ☐
(0-5 yrs only)

Name:	***Address:***
Male ☐ ***Female*** ☐	***Postcode:***
Parents/Carers Name:	***Telephone Number of Parent/Carer:***
Date of Birth: ***Age:***	***GP Name & Address:***
Hospital Number: ***NHS Number:***	***Health Visitor Name & Address:***
Name of School/Playgroup:	***Consultant Name:***
Language spoken at home:	***Diagnosis if applicable:***
Method of Communication:	
Is an interpreter/signer required? Y/N Disabled? Y/N On Disability Register Y/N	

Name of Referrer:	**If referrer is not the parent or guardian please ensure you have their consent and have made them aware that their child may be assessed by one or more of the Multi Disciplinary Team.**
Role:	
Address:	**Parental/Guardian Consent for referral of above child to the Multi Disciplinary Team:**
Telephone Number:	**Signature of Parent/Guardian:** .....
Signature of Referrer:	**Please print name:** .....
Date of Referral:	**Please tick if verbal consent given:** ☐

Family Structure / Family Tree :

Family History :

Mental Health ☐ **Physical Illness** ☐
Learning Disability ☐ **Domestic Violence** ☐
Substance Misuse ☐ **Alcohol Misuse** ☐

CONSENT

In order to offer the most appropriate assessment we would like to discuss this information on this form with the local Child Development Team. This may include Specialist Health Visitor, Children's Therapists (physio, speech, occupational and dietetics) and Early Years Education Team eg. Educational Psychologists. Please state if there is someone you do not wish your child to be discussed with:

_____

What are your main concerns/reasons for this request?

What is the parental level of concern/awareness of difficulties?

How does area of concern impact on the child's/family's everyday functioning?

What has been done to date to address these issues? Eg. Read leaflets, access websites, attend playgroup

Other information

Health (including medications/investigations, equipment, etc):

Education:

Emotional and behavioural development:

Self Care Skills:

Social Circumstances (eg/. housing, etc):

Any other relevant information:

FURTHER DETAILS ABOUT CHILD/YOUNG PERSON
Child Young Person's Ethnicity

Black or Black British	*Asian or Asian British*	*White*	*Mixed*	*Other Ethnic Groups*
Caribbean *African* *Any other Black background*	*Indian* *Pakistani* *Bangladeshi* *Any other Asian background*	*White British* *White Irish* *Any other White background*	*White & Black Caribbean* *White & Black African* *White & Asian* *Any other mixed background*	*Chinese* *Any other ethnic Group* *Not given* *If other, please specify* ……

Further details regarding child/young person's ethnicity:

_____

Child/young person's religion:

_____

Child/Young Person's Nationality (if not British):	
Nationality:	*Home Office Registation Number:*
Immigration Status:	*Asylum seeking/Refugee Status/Exceptional Leave:*

All agencies currently involved, please state:

Social Services ☐ ***Social Worker's Name:*** _____

Portage: ☐ ***Audiology:*** ☐ ***Orthoptics*** ☐ ***Educational Psychologist***

Occupational Therapy/Physiotherapy/Speech & Language / Dietetics/
Other *(please state)**:***

Flying start ☐ ***Please specify area*** _____

	Y	***N***
Is the child on the Child Protection Register?	☐	☐
Is the child a child in need?	☐	☐
Is the child a looked after child?	☐	☐
Are the family a cause for concern?	☐	☐

Please enclose any supporting evidence e.g. MCHAT, SOGS