Pan-Dorset Development and Behaviour Pathway, Referral Form (School Age):

This referral form is to be used to make a referral for a paediatric neurodevelopmental assessment to establish whether there are any underlying health/neurodevelopmental concerns that may be contributing to the child/young person's presentation.

For referral guidance please refer to the Referral Pack available from www.dorsetccg.nhs.uk/services/send

Please complete this form with the parents, print it out, and send by post, or scan and email[1] to:

☐ West of county referrals

Consultant Community Paediatrician
Development and Behaviour Pathway Referral
Dorset County Hospital NHS Foundation Trust
The Children's Centre
Damers Road
Dorchester DT1 2LB

Or email to: paedneuro@dchft.nhs.uk

☐ East of county referrals

Consultant Community Paediatrician
Development and Behaviour Pathway Referral
Poole Hospital NHS Foundation Trust
Child Development Centre (school-age team)
Longfleet Road
Poole BH15 2JB

Or email to: communitypaeds.secretaries@uhd.nhs.uk

*In this form, the sections will expand to accommodate the text you enter. Text can only be entered electronically in the allocated spaces (the rest of the document is locked for editing/formatting). Certain details (such as Name) will be replicated in other parts of this form for your convenience (**Requires Microsoft Word 2010 or later**).*

Child/Young Person's Full Name and Details:

Name[2]: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Gender: Click or tap here to enter text.

Preferred pronoun: He

Address:

Click or tap here to enter text.

NHS Details:

NHS Number *if known*: Click or tap here to enter.

GP Surgery (name/address):

Click or tap here to enter text.

Referrer Details
(please sign and date at the end)

Name: **Ollie Yeats**

Designation: **Deputy Headteacher**

Contact details (address / telephone / email):

Parley Lane, Hurn, Christchurch, Dorset, BH23 6DF.
ollie.yeats@parkfield.bournemouth.sch.uk

Role with the child/family:

Click or tap here to enter text.

Other agencies/professionals involved:
(please indicate the key worker, social worker, etc if exists)

- Click or tap here to enter text.

Please indicate if any of the following apply currently or previously: *Child in Care (CiC); Child in Need (CIN); Child Protection Plan*

- Click or tap here to enter text, or answer as 'none' or 'not-known'.

Special Requirements for child or parent:
(e.g. interpreter, hearing/vision impairment)

Click or tap here to enter text.

Education Setting / School:

Click or tap here to enter text.

[1] Where forms are sent electronically, we require evidence of consent – therefore it is requested that the form with ink signatures are scanned and emailed.

[2] Please give other Surnames if the child might be registered differently with Health Services

This referral form is to be used to make a referral for a paediatric neurodevelopmental assessment to establish whether there are any underlying health/neurodevelopmental concerns that may be contributing to the child/young person's presentation.

Reason(s) for referral: *(concerns from family, concerns from school, strengths/difficulties, impact on child/family/school, etc)*

Reasons/concerns from family:

Click or tap here to enter concerns from family.

Reasons/concerns from school:

Click or tap here to enter concerns from school.

What question(s) do you hope this assessment will help answer? *Are there specific conditions in question (e.g. ADHD, ASD)?*

Click or tap here to enter text.

Existing diagnoses: *(include any known medical conditions, and outcomes/formulations of existing assessments if known, e.g. cognitive, mental health, social care assessments, etc.)* ***Please indicate if any of the items on the right apply, and give details here or attach reports.***

- Click or tap here to enter text.

☐ IEP/SEN plan
☐ Specialist Teaching[3]
☐ Ed Psych
☐ SALT
☐ CAMHS
☐ Early Help / FPZ
☐ Social Care
☐ special sch. outreach
☐ EHCP

Hearing concerns? ☐No ☐Yes ☐Hearing aid user: Click or tap here to enter details.

Vision concerns? ☐No ☐Yes ☐Corrected (e.g. glasses): Click or tap here to enter details.

Communication skills: *(please comment on – ability to follow general instructions; ability to verbalise ideas, needs, preferences; understanding of jokes/sarcasm, literal usage/understanding of language; repetitive use of language)*

Click or tap here to enter text.

Learning/academic levels:

	challenging[4]	below ARE	at ARE[5]	above ARE	Comments
Reading	☐	☐	☐	☐	
Comprehension	☐	☐	☐	☐	
Writing	☐	☐	☐	☐	
Maths	☐	☐	☐	☐	
Overall	☐	☐	☐	☐	
Physical Skills and Coordination	☐	☐	☐	☐	
Social interactions and relationships	☐	☐	☐	☐	
Attention to tasks	☐	☐	☐	☐	

Please summarise any other information on the child/young person's learning or cognitive ability if not already documented above, or, attach separate report(s) e.g. EP report:

Click or tap here to enter text.

[3] **Specialist Teaching Service** includes what was Behaviour Support Service, SENSS/SENISS
[4] This means that the child's performance and/or progress is a cause for concern.
[5] ARE = age-related expectations

Ongoing management:
(graduated response; what has been done / offered / to be done, to support the child/family)

Guidance Note: *Although acceptance of the referral is not dependent upon completion of these interventions, it is expected that a **graduated response** is implemented before referral.*

SCHOOL-BASED SUPPORT

Learning assessment done? Click or tap here to enter text.

Adjustments to learning environment (e.g. IEP)? Click or tap here to enter text.

Sensory interventions? Click or tap here to enter text.

Access to ELSA/SULP? Click or tap here to enter text.

Total communication strategies? Click or tap here to enter text.

Learn-To-Move/Move-To-Learn Programme? Click or tap here to enter text.

Other strategies tried in school? Click or tap here to enter text.

HOME-BASED SUPPORT

Evidence-based behaviour management courses[6] for parents? Click or tap here to enter text (include name of programme).

Other strategies tried in the home? Click or tap here to enter text.

Other parental experience/training? Click or tap here to enter text.

Referrals to other agencies for support at home e.g. Early Help/FPZ? Click or tap here to enter text.

Any other comments? Click or tap here to enter text.

Family and social background:
(including employment, relevant health issues, social care, housing, etc)

Click or tap here to enter text.

Parent/Carer name(s):

- Click or tap here to enter text.

Siblings/other household members:

- Click or tap here to enter text.

Are there concerns regarding the child/young person's emotional wellbeing due to external life events, family, or social difficulties? *If yes, please provide as much detail as possible, or attach available reports e.g. minutes from TAF/CAF meetings, Early Help Assessments, Social Care reports, CAMHS information, Safeguarding information, etc. See also Guidance Notes (childhood adversity checklist).*

Click or tap here to enter text.

Any other information or comments:

Click or tap here to enter text.

[6] For example: Incredible Years / Triple P

Consent:

Please ensure that the referral questions (above) have been discussed/agreed with the parents, and/or young person if applicable. Please involve the young person where possible. Please indicate below that appropriate consent has been obtained (see footnotes).

Consent of parent/carer with Parental Responsibility:

For this referral to the paediatric department: ☐No ☐Yes

For relevant information to be shared with the appropriate professionals: ☐No ☐Yes

For the GP (Family Doctor) to share relevant health information relating to this child/young-person, and parent/guardian/family: ☐No ☐Yes

Consent of the young person:

For this referral to the paediatric department (*1): ☐No ☐Yes

For relevant information to be shared (*2) with the appropriate professionals: ☐No ☐Yes

*(*1) Usually if aged 16 or above. See https://www.nhs.uk/conditions/consent-to-treatment/children/ for guidance.* ***Note: the service in Poole Hospital does not accept referrals for young people aged 16 and over.***

*(*2) Children aged 13 years or older can give consent for data processing (sharing). Data Protection Act 2018*

Referrer Name and Signature: see checklist below	**Parent/Guardian[7] Name and Signature:**
…… Ollie Yeats **Date:** Click or tap to enter a date.	…… Click or tap here to enter name. **Date:** Click or tap to enter a date. If you consent to receiving communications via email (e.g., requests for questionnaires) can you please include your email details below. Click or tap here to enter text.

Checklist:

Please ensure the following have been completed:

[ ] Consent for referral and information sharing obtained?

[ ] Supporting information or attachments, if applicable, enclosed (please list below)?

[ ] Tear-off sheet sent off to notify the GP?

Documents/questionnaires attached:

- Click or tap here to enter text.

[7] Person with Parental Responsibility

Guidance Notes:

Childhood Adversity Checklist:

In the first 18 years of life, did the following ever occur? If so – please give further details if possible.

1. The child was exposed to situations where they felt threatened, were humiliated, or treated punitively by a parent or adult in the household
2. Experience physical abuse at the hands of a parent or adult within the household
3. The child was a victim of sexual abuse at the hands of someone 5yrs older or more
4. Chronic neglect and a lack of protection provided by the parent/carer
5. Parental separation or divorce
6. Witness to domestic abuse/aggression between parents/carers
7. Parental substance use
8. Parental mental health difficulties (at any time)
9. Parent going to prison

END OF GUIDANCE NOTES

Tear-off sheet, to be sent to the child/young person's GP. Optional Response Sheet Overleaf

Date: <auto-completed field>

<auto-completed field>

Dear Dr,

Name: <auto-completed field>	DOB: <auto-completed field>
<auto-completed field>	<auto-completed field>

The above-named child has been referred by the school to the paediatric department for a neurodevelopmental assessment due to concerns about their development and/or unusual behaviour.

A copy of the referral form:

☐ is enclosed for your information[8]

☐ is not enclosed, but can be shared on request

If you have any information that may be useful for the paediatric team to consider, please contact the paediatric department in:

☐ Dorset County Hospital

☐ Poole Hospital

To respond to the paediatric department, you may use the optional response sheet on the other side, or send a separate letter. *Please verify that you are satisfied with the consent for information sharing as recorded in the enclosed copy of the referral form; or seek further consent if needed.*

Yours sincerely

……..

Name: **Ollie Yeats**

Designation: **Deputy Headteacher**

Parley Lane, Hurn, Christchurch, Dorset, BH23 6DF.
ollie.yeats@parkfield.bournemouth.sch.uk

[8] It is suggested that this back page is flipped over to the front, if an entire copy is being sent to the GP

Optional Response Sheet for the GP to send to the Paediatric Department.

Date: _____

Please send to:

Consultant Community Paediatrician (Development and Behaviour Pathway Referral) at

☐ Dorset County Hospital

☐ Poole Hospital

Dear colleague,

Name: <auto-completed field>	DOB: <auto-completed field>
<auto-completed field>	<auto-completed field>

I have been informed that the school has referred my patient to your department for a neurodevelopmental assessment.

☐ I have received a copy of the referral form from the school

☐ I have not received a copy of the referral form from the school

I enclose the following information in support of this referral:

☐ I have no additional relevant information to contribute

☐ Summary Sheet with Past Medical History, Medication, and, Allergies

☐ Letter(s) / Reports(s):

☐ Other:

Yours sincerely,