# REFERRAL TO COMMUNITY PAEDIATRICS

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| **Name of Child:** | | Click here to enter text. | | | **DOB/CHI:**Click here to enter text. | |  |
| **Current Address:**Click here to enter text. | | | | | | | |
| **Parent/Carer Name:** | | | Click here to enter text. | | | | |
| **Tel No: (Land line)** | | | Click here to enter text. | **School:**Click here to enter text. | | | |
| **Tel No: (Mobile)** | | | Click here to enter text. |
| **Interpreter Required:** Choose an item. | | | | **Which Language?**Click here to enter text. | | | |
| **Reason for Referral:**  Click here to enter text. | | | | | | | |
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| **What are the parent/carer’s concerns? Do they have a specific condition they wish to explore?**  Click here to enter text. | | | | | | | |
| **Educational Assessment:** (i.e IEP Targets, Educational psychology reports, Child Planning Meeting minutes. Please include CFE levels and any SNSA results)  Click here to enter text. | | | | | | | |
| **Other Professionals involved:**Click here to enter text. | | | | | | | |
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| **Any known Medical Information:** (i.e. medical history, Any concerns with hearing or vision, concerns about growth) | | | | | | | |
| Click here to enter text. | | | | | | | |
| **Family/ Social history:**  Click here to enter text. | | | | | | | |
| **Communication:** (i.e. understanding of instructions, vocabulary, fluency, non verbal skills, social use of language) | | | | | | | |
| Click here to enter text. | | | | | | | |
| **Mobility/Gross motor skills:** (i.e. can child sit/walk, use stairs and access large play equipment, concerns re: balance/co-ordination) | | | | | | | |
| Click here to enter text. | | | | | | | |
| **Hand/Fine Motor skills(**e.g. can the child dress themselves, what do they use to eat and how do they hold a pencil?) | | | | | | | |
| **Social interactions:** (i.e. interest in toys, turn taking, playing with peers, role play, imagination) | | | | | | | |
| Click here to enter text. | | | | | | | |
| **Behaviour:** (i.e. friendships, interests, changes in routine, aggression, activity level, impulsivity, mood, focus on school) | | | | | | | |
| Click here to enter text. | | | | | | | |
| **Is there cause for concern?** (i.e..social worker, Child Protection Registrar, LAC)Choose an item. | | | | | | | |
| Please give details: | | | | | | | |
| **Are there likely to be any problems with attendance at the appointment? What support may be helpful?**Click here to enter text. | | | | | | | |
|  | | | | | | | |
| **Assessment of Wellbeing or Child’s Plan included with Referral:** Choose an item. | | | | | | | |
| **Have the parents and child/young person consented to referral?**Choose an item. | | | | | | | |
|  | | | | | | | |
| ***We cannot accept a referral without the appropriate consent*** | | | | | | | |
| **Requested by:** | Click here to enter text. | | | | | | |
| **Designation:** | Click here to enter text. | | | | | | |
| **Contact Tel No:** | Click here to enter text. | | | | | **Date:**Click here to enter text. | |
| **Contact Address of Referrer:** | | | | | | | |
| Click here to enter text. | | | | | | | |
| Please send completed form to: [ChildrensWaitingListTeam@nhslothian.scot.nhs.uk](mailto:ChildrensWaitingListTeam@nhslothian.scot.nhs.uk) Community Paediatrics (formerly Community Child Health), for Edinburgh, East & Midlothian and West Lothian | | | | | | | |

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