**Children’s, Young People’s and Families Services**

**Peterborough Integrated Neurodevelopmental Referral Form**

**- for neurodevelopment assessment.**

|  |  |
| --- | --- |
| ***Only use this referral form if the child’s GP is part of the Peterborough PCN – please redirect to local services if out of area.*** | |
| **Name of Child:** | **Date of Birth:** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Address:** | **Post Code:** | | | | |
| **NHS No. (If known):** |  | | | | |
| **Contact Details:** | **Mobile:** | **Home:** | | | **Alternate:** |
| **Email\*:**  \* *By providing your email address you give us consent to contact you with confidential information via non-secure email* | | | | |
| **Please name who has parental responsibility for the child:** |  | | | | |
| **GP Surgery:** |  | | | | |
| ***Only use this referral form if the child’s GP is part of the Peterborough PCN – please redirect to local services if out of area.*** | | | | | |
| **School attended:**  ***(full address)*** | **Post Code:** | | | | |
| **Referral form completed by:** | **Name:** | | **Job Title:** | | |
| **Referrer Contact details:** | **Tel:** | | | | |
| **Email\*:**  \* *By providing your email address parents give us consent to contact you with confidential information via non-secure email* | | | | |
| **Date of completion:** | Click or tap to enter a date. | | | | |
| **Are the child and / or family involved with, or previously been known to, social care?** | | | | **Yes No** | |
| **If yes, please provide details of their social worker:** | **Name:**  **Tel:**  **Email:** | | | | |
| **Are they currently on a Child Protection Plan?** | | | | **Yes No** | |
| **Is an interpreter required for any appointment?** | | | | **Yes No** | |
| **If yes, please specify language:** |  | | | | |

**Please read before completing:**

This referral form is exclusively for young people (**up to their 18th birthday**) who are seeking a referral for an assessment of a neurodevelopmental condition and who are registered with a GP surgery in Peterborough (this includes Yaxley, Wittering and Whittlesey).

For **primary-age children**, the Community Paediatricians will initially offer a General Developmental Assessment (GDA) to consider if a more focused assessment from the CAMHS Neurodevelopmental team is required. For **secondary-age children**, the CAMHS Neurodevelopmental Team will offer focused assessments outlined by the relevant NICE guidance.

The threshold for a specialist assessment is high and to meet threshold we will need to see evidence of a number of interventions that have taken place for the young person prior to this being considered. We work closely with the local authority and MASG panel who feed into the assessment process. If the young person is not already open to an **Early Help Assessment**, then this **must be completed** before a referral is made.

As part of this referral information from parents, child and school will be considered. However **please make clear who is supplying the information**. We recognise that the views of parents and professionals may differ and therefore it is helpful to understand whose views are being reflected. We would expect that most of the information supplied in this form will come from the school setting, with additional information from home. It is important that relevant social and family circumstances are also included. If there is additional social care involvement then this, if not already included in the EHA, should also be included in this form. Information should be concise and relevant.

|  |
| --- |
| **All referrals and supporting documents to be sent to the YOUnited Referral Hub**  **Email:** [younited@cpft.nhs.uk](mailto:younited@cpft.nhs.uk)  **Post:** YOUnited,c/o Kingfisher House, Kingfisher Way, Huntingdon PE29 6FN  **Telephone:** 0300 3000 830 **(calls monitored Mon to Fri 9am to 5pm)**  **If the referral form is not completed or supporting documentation is not included, the Referral Hub will not be able to process the referral and will close it.** |

|  |  |
| --- | --- |
| **1. What is the primary reason for this referral?** | |
| 1. Social Communication/Autistic Spectrum Disorder assessment (ASD) |  |
| 1. Attention and hyperactivity out of keeping with developmental level (ADHD) |  |
| 1. Other (please specify): |  |

|  |  |
| --- | --- |
| **Please include all the following mandatory documents** | **Check box if included** |
| **Early Help Assessment (EHA)** |  |
| **Developmental History** |  |
| **School Report / APDR / EHCP (completed by SEND Teacher / Ed. Psych.)** |  |
| **Safeguarding information** (if applicable) |  |
| **Information regarding social and home circumstances (not included in EHA)** |  |
| **Any other professional reports available (please list below):** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Information Governance** | | | |
| **Referrer** - please ask the young person or parent/carer the following questions: | | | |
| Do you consent to your / your child’s shared care record (used by other organisations using the SystmOne electronic patient record system such as your GP) being accessed by YOUnited / CPFT?  Simplified: Are you happy for us to be able to access your child’s health record? | | | **Yes No** |
| Do you consent to us (YOUnited / CPFT) adding information relating to your / your child’s care to their SystmOne shared care record which may be viewed by other NHS professionals such as your/their GP?  Simplified:  Are you happy for us to share your child’s care details with their GP and other NHS professionals on their health record? | | | **Yes No** |
| **Do parents agree to the sharing of this information with all relevant agencies:** | | | **Yes No** |
| **If no, please specify reasons:** | | | |
| **Parents/Carers:** | **Sign:** | | |
| **Print:** | **Date:** | |
| **Relationship to the young person:** | | | |
| **Does the young person agree to this referral being made?** | | | **Yes No** |
| **If no, please specify reasons:** | | | |
| **Do both parents live in the family home?** | | | **Yes No** |
| **If no, can information including child’s address be shared with both parents?** | | | **Yes No** |
| **Please provide the details of parent not living in the family home if information can be shared:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **2. Do the child’s parents have concerns and what are they?** | | | |
| **Please consider the following areas**:  2.1 Social Interaction and Managing Relationships  2.2 Interaction with others  2.3 Attention and Concentration  2.4 Behaviour  2.5 Mental Health and Emotional Wellbeing  2.6 General Health | | | |
| **3. Are the parents looking for:** | | | |
| **Diagnosis request (including medical investigations)** | | | **Yes No** |
| **Intervention and support** | | | **Yes No** |
| **4. Does school have concerns and what are they?**  ***Please consider in terms of social communication / behavioural / learning domains*** | | | |
| **Please consider the following areas**:  4.1 Communication skills  4.2 Interaction with peers  4.3 Attention and concentration  4.4 Behaviour  4.5 Unusual interests and routines  4.6 Sensory issues  4.7 Mental Health and Emotional Wellbeing  4.8 General Health | | | |
| **5. Please list what support and strategies are currently being implemented at school and include Assess, Plan, Do and Review cycle (if applicable) with this form.**  ***Consider what effect these interventions have had.***  ***Attach relevant SEND report with this referral.*** | | | |
| **5.1. Do the family and school have similar concerns? If no, please state how these differ:** | | | |
| **6. Please list support and strategies that have been offered and taken up by the family.**  ***If there is a significant behavioural concern, we would expect that parents would have accessed some support prior to this referral having been made. Include what behaviour support or evidence-based parenting classes have been accessed, including the name and dates. Please include certificates if available.*** | | | |
|  | | | |
| **7. Please give any relevant information regarding child’s home setting, include parents and other significant family members, relevant social factors which may have some impact on a child’s presentation *(if not already included in the EHA)*.**  ***Include details of separation, bereavement, parental mental health, drug or alcohol issues etc.***  ***Insufficient information here will result in a delay.*** | | | |
|  | | | |
| **8. Is this child’s academic attainment in line with their peers?** | | | **Yes No** |
| **8.1 If no, please quantify the gap using school measures, including current level*.***  ***Please provide a key/brief description of school measures used, including expected levels***  ***for the child’s year group.*** | | | |
|  | **Current** | **Expected for age** | |
| **Maths** |  |  | |
| **English** |  |  | |
| **Science** |  |  | |
| **Reading** |  |  | |
| **Writing** |  |  | |

|  |  |
| --- | --- |
| **8.2 Is this child’s academic attainment in line with their ability?** | **Yes No** |
| **If no, what do you see as the barriers.** | |
| **8.3 Is this child on a reduced timetable?** | **Yes No** |
| **If yes, please specify:** | |
| **8.4 Is the child spending time outside the classroom on a regular basis?** | **Yes No** |
| **If yes, please specify:** | |
| **8.5 Is school attendance a problem?** | **Yes No** |
| **If yes, please specify:** | |
| **8.6 Is this child in receipt of an EHCP or has additional support in school?** | **Yes No** |
| **If yes, please give detail:** | |
| **9. Please add any other relevant information which you feel is important for us to know when considering this child:** | |
|  | |