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

Information for completing the Referral Form: Childrens Development Team, Community, Swansea

(Therapies / Paediatricians)

- ***This referral form is for referring Children and Young People*** *(0 – 19 years)* ***to The Childrens Development Team*** (MDT), ***which includes Physiotherapy; Occupational Therapy; Speech and Language Therapy*** *(0-5 years only)*; ***Community Paediatricians*** *(0-5 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***

Note: *Please attach any competed assessments / reports i.e. SOGS, Ruth Griffiths, MCHAT etc*

Return the Referral form to:

PHYSIOTHERAPY / OCCUPATIONAL THERAPY SERVICES
The MDT Referral Team
Hafan Y Môr
Singleton Hospital
Sketty Lane
Swansea
SA2 8QA

Telephone: ***01792 200400***
Fax No: ***01792 285372***

PAEDIATRICIAN / SPEECH THERAPY
Child Health Department
Trinity Building
21 Orchard Street
Swansea
SA1 5AT

Telephone: ***01792 651501***
Fax No: ***01792 642049***

Referral Form for MD T – Paediatric Community Services, SWANSEA

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***	☐	***COMMUNITY PAEDIATRICIAN*** (0-5 yrs only)	☐	***SPEECH & LANGUAGE*** (0-5 yrs only)	☐

Name:	***Address:***
Male ☐ ***Female*** ☐	***Postcode:***
Parents/Carers Name:	***Telephone Number of Parent/Carer:***
Date of Birth: ***Age:***	
Hospital Number: ***NHS Number:***	***GP Name & Address:***
Name of School/Playgroup:	***Health Visitor Name & Address:***
Language spoken at home:	***Consultant Name:***
Method of Communication:	

Reason for Referral:

Patient/Carer's Primary Concern:

Diagnosis:

Present/Past Medical History & Family History:

Medication/Investigations:

All agencies currently involved, please state :

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

Portage: ☐ ***Audiology:*** ☐ ***Orthoptics*** ☐

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

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

Are there any Health & Safety/ Risk issues known relating to this family? **Yes / No**

Please specify if Yes (if further space required please continue in any other relevant section)

Please explain how the child/young person has difficulties in the following areas:

Areas of Difficulties	*Yes*	***Please explain all difficulties below :***
* *PLEASE INCLUDE AS STATED ON FRONT COVER – ASSESSMENTS / REPORTS FOR EXAMPLE: SOGS, RUTH GRIFFITHS, MCHAT* *		
Achieving Milestones	*	
Feeding/swallowing *E.g., coughing or choking while eating/drinking*		
Attention & Listening * *E.g., age related turn taking, paying attention or settle on tasks*	*	
Interaction/Play * *E.g., playing alone/with others, making eye contact, sharing*	*	
Understanding Spoken Language *E.g.: following instructions*		
Using Spoken Language *E.g., words/sentences to communicate*		
Speech Sounds *E.g., is speech understood by family/friends*		
Positioning & Handling *E.g., with sitting unaided, upset when moved*		
Respiratory Complications *E.g., re-current chest infection/shortness of breath*		
Pre / Post Surgery *Please give details*		
Equipment Required *E.g., splints, specialist equipment for bathing/toileting/seating/standing*		
Sensory Difficulties *E.g., Particularly sensitive, food tolerance, taste & textures, noise, touch, movement*		
Fine Motor Skills * *E.g., hand preference, handwriting manipulation, cutlery*	*	
Gross Motor Skills * *E.g., hopping, skipping, crawling, balancing, jumping*	*	
Perceptual Skills *E.g., spatial/body awareness, knowing left & right, up & down, back & front*		
Activities of Daily Living *E.g., independent ability for daily living tasks, e.g. dressing, undressing, eating, toileting*		
Concerns highlighted on MCHAT / or around ASD * *Please attach any relevant information*	*	
Other - *Please state*		

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Any other relevant information:
(Please continue overleaf if necessary)

Please ensure you include/attach *(PLEASE TICK):*

ASSESSMENTS / REPORTS ***SOGS*** ☐ ***RUTH GRIFFITHS*** ☐ ***MCHAT*** ☐ ***OTHER*** ☐

Referrals may be delayed or rejected if the above are not attached

REFERRER DETAILS

Name of Referrer:

Title of Referrer:

Address:

Telephone Number:

Signature of Referrer:

Date of Referral:

Parental/Guardian Consent: *Verbal* ☐

Signature:.....

Print Name:.....

Please turn over for discussion / outcome – to be completed by Administration / Manager / Team members present at referral meeting

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FOR OFFICE USE ONLY

Referral Meeting Details *Date Referral* ***Received:*** _____ *Date Referral* ***Discussed:*** _____

Lead/Present:

Community Paediatrician	Occupational Therapist	Physiotherapist	Speech & Language Therapist
Admin	Other -specify	Other -specify	Other -specify

Outcome

Disciplines agreed outcome: _____

SALT ☐ *OT* ☐ *PAEDIATRICIANS* ☐ *PHYSIO* ☐ *MULTI-DISCIPLINARY (MDT)* ☐

INTEGRATED CARE PATHWAY (ICP) ☐

DEVELOPMENTAL COORDINATION DISORDER (DCD) ☐

Dietetics ☐

Appointment Details (If accepted)

Date appointed: _____ *Team members to attend:* _____

Other Invitees (i.e. Health Visitor etc) _____

Admin actions: Referral form copied to: _____ *Date appointment sent:* _____

Date Contact received by Parent / Guardian Attending Y / N

PIMS+ Info: _____

Referral Input onto ☐ ***PIMS+***

☐ ***Local Records:***

Input By: ***Date:***

Any further information (include date, name and details):

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