People at our heart

NHS
Coventry and Warwickshire Partnership
NHS Trust

Children & Young People

Complex Physical Health

New to Country/New to City MDT Referral form

This MDT referral form is for Children or Young people who are New to Coventry with complex physical health needs requiring input from multiple physical health services. On acceptance of this referral, the CYP will be triaged to determine which services are required in which priority.

Child or young person being referred

Surname of Child/Young Person			
First Name(s)			
Date of Birth		Age of Child	
NHS Number			
Gender (please tick)	Male ☐	Female ☐	
Address			
Postcode			

Ethnicity Category (please tick)

☐ White British	☐ Mixed White and Black African	☐ Asian/Asian British Pakistani	☐ Black/Black British other	☐ Other Ethnic Group
☐ White Irish	☐ Mixed White and Black Asian	☐ Asian/Asian British Bangladeshi	☐ Eastern European	☐ Not known
☐ White/Other White Background	☐ Mixed Other Background	☐ Asian/Asian British Caribbean	☐ Black/Black British African	☐ Not stated
☐ Mixed White and Black Caribbean	☐ Asian/Asian British Indian	☐ Other Ethnic Groups Chinese	☐ Eastern European	

Details of Parent/Carer

Parent Carer's Name(s)			
Relationship to child/young person			
Address *(if different from above)*			
Email address *(consent to receive emails if given)*			
Telephone contact number		Consent to SMS text reminder	Yes ☐ No ☐

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Home Language CWPT values multilingualism and views this as an advantage. The Trust encourages families to communicate with their children in the way which feels most natural which will include using languages used in the home environment.	Is an Interpreter required?	Yes ☐ No ☐
	If yes, please state which language:	

IMPORTANT: Referral Information required

Please indicate by ticking the below boxes the services the Child/Young Person may require. (Must be two or more)

If the CYP requires only one service referral, please follow the existing referral route.

Community Paediatrics ☐	Children's Physiotherapy ☐	Children's Respiratory Physiotherapy ☐
Children's Occupational Therapy ☐	Children's Dysphagia ☐	Children's Bladder & Bowel ☐
Children's Community Nursing ☐	Children's Dietetics ☐	

For other Services not noted please follow existing referral route

Referrer Details

Referred by Full Name				
Referrers address				
Postcode				
Referrers telephone number				
Designation or relationship to Child/Young Person				
Is this Child/Young Person known/being seen by other services – please tick to indicate which	Are known to Social Care	☐	Child Protection Plan	☐
	In the care of the Local Authority	☐	(if yes above) Do they have a Social Worker	☐
Please details diagnosis and health needs				
Please detail current medications including dose				
Referrer Signature *(electronic is acceptable)*				
Referral Date				

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Please tick to indicate you have attached medical letters, reports, scans, and information regarding any referrals made to other services ☐			
GP Details **Must be completed for referral to be proceeded**			
GP Name			
GP Practise address			
Postcode		GP telephone number	
Please return referral and attach any other relevant medical information [scans, clinic letters, reports etc] by email to ChildrensPhysicalHealth@covwarkpt.nhs.uk Or by post to: Children's Physical Health Referrals, Wayside House, Wilsons Lane, Coventry CV6 6NY			