

## Children's Physical Health Single Point of Access

# Complex Physical Health MDT Referral Form

*Previously New to Country/City*

This referral form is for Children or Young people with complex physical health needs who are new to requiring MDT (Multidisciplinary Team) input from multiple physical health services. This includes children and young people who are new to country/city.

On acceptance of this referral, the child or young person will be triaged to determine which services are required in which priority.

### Please select one of the below

|                     |                          |                            |                          |
|---------------------|--------------------------|----------------------------|--------------------------|
| New to Country/City | <input type="checkbox"/> | New to requiring MDT input | <input type="checkbox"/> |
|---------------------|--------------------------|----------------------------|--------------------------|

### 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 <input type="checkbox"/> | Female <input type="checkbox"/> |  |
| Address                       |                               |                                 |  |
| Postcode                      |                               |                                 |  |

### Ethnicity Category (please tick)

|                                                          |                                                        |                                                          |                                                      |                                             |
|----------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> White British                   | <input type="checkbox"/> Mixed White and Black African | <input type="checkbox"/> Asian/Asian British Pakistani   | <input type="checkbox"/> Black/Black British other   | <input type="checkbox"/> Other Ethnic Group |
| <input type="checkbox"/> White Irish                     | <input type="checkbox"/> Mixed White and Black Asian   | <input type="checkbox"/> Asian/Asian British Bangladeshi | <input type="checkbox"/> Eastern European            | <input type="checkbox"/> Not known          |
| <input type="checkbox"/> White/Other White Background    | <input type="checkbox"/> Mixed Other Background        | <input type="checkbox"/> Asian/Asian British Caribbean   | <input type="checkbox"/> Black/Black British African | <input type="checkbox"/> Not stated         |
| <input type="checkbox"/> Mixed White and Black Caribbean | <input type="checkbox"/> Asian/Asian British Indian    | <input type="checkbox"/> Other Ethnic Groups Chinese     | <input type="checkbox"/> 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) |  |

[Type here]

|                                                                                                                                                                                                                                                        |                                      |                                                          |                              |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------|------------------------------|----------------------------------------------------------|
| Telephone contact number                                                                                                                                                                                                                               |                                      |                                                          | Consent to SMS text reminder | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Home Language<br><br>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 <input type="checkbox"/> No <input type="checkbox"/> |                              |                                                          |
|                                                                                                                                                                                                                                                        | If yes, please state which language: |                                                          |                              |                                                          |

## Referral Information

### IMPORTANT: Referral Information required

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

If the Child/Young Person requires only one service referral, please follow the existing referral route.

|                                                          |                                                   |                                                               |
|----------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------|
| Community Paediatrics <input type="checkbox"/>           | Children's Physiotherapy <input type="checkbox"/> | Children's Respiratory Physiotherapy <input type="checkbox"/> |
| Children's Occupational Therapy <input type="checkbox"/> | Children's Dysphagia <input type="checkbox"/>     | Children's Bladder & Bowel <input type="checkbox"/>           |
| Children's Community Nursing <input type="checkbox"/>    | Children's Dietetics <input type="checkbox"/>     | Wheelchair Services <input type="checkbox"/>                  |
| Please detail diagnosis and health needs                 |                                                   |                                                               |
| Please detail current medications including dose         |                                                   |                                                               |

[Type here]

|                                                                                               |                                    |                          |                                             |                          |
|-----------------------------------------------------------------------------------------------|------------------------------------|--------------------------|---------------------------------------------|--------------------------|
| Is this Child/Young Person known/being seen by other services – please tick to indicate which | Are known to Social Care           | <input type="checkbox"/> | Child Protection Plan                       | <input type="checkbox"/> |
|                                                                                               | In the care of the Local Authority | <input type="checkbox"/> | (if yes above) Do they have a Social Worker | <input type="checkbox"/> |

## Referrer Details

|                                                                                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Referred by Full Name                                                                                                                                              |  |
| Referrers email address                                                                                                                                            |  |
| Referrers address                                                                                                                                                  |  |
| Postcode                                                                                                                                                           |  |
| Referrers telephone number                                                                                                                                         |  |
| Designation or relationship to Child or Young Person                                                                                                               |  |
| Referrer Signature<br>( <i>electronic is acceptable</i> )                                                                                                          |  |
| Referral Date                                                                                                                                                      |  |
| Please tick to indicate you have attached medical letters, reports, scans, and information regarding any referrals made to other services <input type="checkbox"/> |  |

## GP Details (Coventry only CV1 – CV6)

Section must be complete for referral to proceed

|                                                                                                          |  |                     |  |
|----------------------------------------------------------------------------------------------------------|--|---------------------|--|
| GP Name                                                                                                  |  |                     |  |
| GP Practice address                                                                                      |  |                     |  |
| Postcode                                                                                                 |  | GP telephone number |  |
| If child or young person is not registered with a GP please detail actions taken to support registration |  |                     |  |

**Please return referral and attach any other relevant medical information [scans, clinic letters, reports etc] by email to [Referrals.ChildrensPhysicalHealth@covwarkpt.nhs.uk](mailto:Referrals.ChildrensPhysicalHealth@covwarkpt.nhs.uk)**

Or by post to: Children's Physical Health Referrals, Wayside House, Wilsons Lane, Coventry CV6 6NY