**REFERRAL FORM**

For Consideration of Eligibility for Continuing Care funding

Date Referral Form submitted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Child’s Name** |  |
| **Date of Birth & Age at time of referral** |  |
| **NHS Number** |  |
| **Does this child have an EHCP?** | **YES/NO** |
| **Home Address** |  |
| **GP and name of Surgery** |  |
| **Is this a Cared-for Child?** |  |
| **Name of person with PR** |  |
| **Placement / Current Address (if different to address above)** |  |
| **List any safeguarding concerns** |  |
| **Does the child/ young person have capacity?** | **YES/NO**  **N/A** |
| **Is a DoLS required?** |  |
| **Who has signed consent?** |  |

|  |  |
| --- | --- |
| **REFERRER** | |
| **Name** |  |
| **Title** |  |
| **Organisation** |  |
| **Address** |  |
| **Email** |  |
| **Contact Number** |  |

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| **Primary Health Need**  Mental Health  Learning Disability  Complex Physical Health |
| **Reason for referral / overview of needs:** |
| **If appropriate, Details of existing package including costs and how this is funded. i.e Health or Social Care.** |

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| **Please enter contact details of Family, GP and other key professionals involved in the management of the child/young person below;** |
| **It is essential in order for the referral to progress that all contact details are provided. If not this referral will be rejected.** |

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| --- | --- | --- |
| **Name and Title / Relationship to Child / Young Person** | **Telephone and email** | **In Support of referral (**Please tick**)** |
| Parents/ Guardians |  |  |
| Community Paediatrician |  |  |
| Lead Consultant (please state specialty) |  |  |
| Other Consultant (please state specialty) |  |  |
| Specialist Nurse |  |  |
| Social Worker |  |  |
| Lead Education Worker (e.g, SENCO) |  |  |
| Education Officer |  |  |
| School Nurse |  |  |
| Occupational Therapist |  |  |
| Dietician |  |  |
| SALT |  |  |
| Physiotherapist |  |  |
| Named Contact for Care Agency / Service Provider (if applicable)  Please include any therapists that are being accessed. |  |  |
| Other |  |  |

|  |  |
| --- | --- |
| Required Information | *Please tick* |
| Signed and completed consent form attached: |  |
| Pen Picture attached: |  |

*Please note, this referral cannot progress without all requested attachments*

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| Other supporting information  Eg: Statement of SEN/EHC Plan, Assessments, Reports, Care Plans etc. | Date and Author |
|  |  |
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|  |  |

**Please password-protect if necessary and email to the Children’s Complex Care Team at** [**complexcare.admin@nhs.net**](mailto:complexcare.admin@nhs.net)