NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Children's, Young People's and Families Services

Cambridge, Huntingdon and Fenland Neurodevelopmental Referral Form- for neurodevelopment assessment.

Only use this referral from if the child's GP is part of the Camridgeshire 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 from if the child's GP is part of the Cambridgeshire PCN – Please redirect to local services if out of area.			
School attends: ***(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.		

Please read before completing:

This referral form is exclusively for young people (up to the 18th birthday) who are seeking a referral for an assessment of a neurodevelopmental disorder who are registered with a GP surgery in Cambridgeshire.

Cambridgeshire CAMHS are only commissioned to provide neurodevelopmental assessments to secondary school age children. The CAMHS Neurodevelopmental Team will offer the focused assessments outlined by NICE guidance for these diagnoses.

For primary school age children, the current agreed pathway is through Community Paediatricians within the CCS NHS Child Health Teams.

The threshold for these specialist assessments is very high and to meet this threshold we will need to see evidence of a number of interventions that have taken place for the young person to be considered for such an assessment. Where

possible, we will work closely with the local authority who feed into the assessment process... If they are not already open to an Early Help Assessment, then this needs to be considered 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 the majority 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.

Referrals and supporting documents to be sent to the YOUnited Referral Hub
Email:younited@cpft.nhs.uk
Post: C/O, Kingfisher House, Hinchingbrooke Business Park, Kingfisher Way, Huntingdon PE29 6FN
Telephone: 0300 3000 830.
Opening Hours: Monday to Friday 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?		**X**
1.	Social Communication/Autistic Spectrum Condition assessment	☐
2.	Attention and hyperactivity out of keeping with developmental level (ADHD)	☐
3.	Medical assessment to consider investigation for significant learning disability. (Please note that an Educational Psychology report or school report clearly identifying the learning needs will need to be provided)	☐
4.	Other. Please specify:	☐

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 have similar concerns to school: Yes☐ No☐

5.2 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 parenting classes have been accessed, including the name and dates. Please include certificates if available. Referrals will not be accepted until behavioural support for parenting has been accessed.***
7. Please give any relevant information regarding a 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 the child and/or family involved with, or previously been known to, Social Care? Yes☐ No☐
8.1 If yes please provide the details of their Social Worker:

Name: **Tel:** **Email:**	

8.2 Are they currently on a Child Protection Plan: Yes ☐ No☐
9. Is this child's academic attainment in line with their peers: Yes☐ No☐
9.1 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		

9.2 Is this child's academic attainment in line with their ability: Yes☐ No☐
If no what do you see to be the barriers.
9.3 Is this child on a reduced time table: Yes☐ No☐
If yes please specify:
9.4 Is the child spending time outside the classroom on a regular basis: Yes☐ No☐
If yes please specify:
9.5 Is school attendance a problem: Yes☐ No☐
If yes please specify:
9.6 Is this child in receipt of an EHCP or has additional support in school: Yes☐ No☐
If yes please give detail:
10. Please add any other relevant information which you feel is important for us to know when considering this child:

Please specify and include the information required.	X if included
Early Help Assessment (EHA)	☐
Social Communication Descriptors (for ASC/Social Communication ONLY)	☐
SEND Report (Specialist Teacher / Educational Psychologist)	☐
Safeguarding information	☐
Assess, Plan, Do, Review cycle	☐
Information regarding social and home circumstances (not already included in EHA)	☐

Any other professional reports available (please list below):

-
-
-
-
-

Would an interpreter be required for an appointment: Yes☐ No☐	
If yes please specify language:	

Information Governance

Referrer
Please ask the young person/parent/carer the following questions:

Do you consent to your/your child's shared care record (used by other organisations using the Systm1 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?	Yes ☐ No ☐

(Simplified: Are you happy for us to share your childs care details with their GP and other NHS professionals on their health record?)	

Do parents agree to the sharing of this information with <u>ALL</u> relevant agencies: Yes☐ No☐		
If no, please specify reasons:		
Parents/Carers:	**Sign:**	
	Print:	
Relationship to child:		
Date:		
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 <u>can</u> be shared:

Information and referral form shared by CCS and formatted and amended for use by CPFT referral process (agreed December 2020)