Blackpool Teaching Hospitals NHS
NHS Foundation Trust

FYLDE COAST CHILDRENS AND YOUNG PEOPLES COMMUNITY SERVICES SINGLE POINT OF ACCESS - REFERRAL FORM

Please complete this form (or send a Paediatrician's detailed clinic letter) and use the form on the website to return to the service, or email to bfwh.admin.paediatrictherapy@nhs.net

Please identify if this is an urgent referral within the subject line of the email.

All sections marked with * are mandatory

Child/Young Person`s Details:

Surname*		**School/Nursery setting***	
Forename*		**Language speaks/Understands***	
Date of Birth*		**NHS Number**	
Address*		**Year Group***	
		Health Visitor /School Nurse	
Post code*		**Child Looked After by the Local Authority - Yes/No***	Yes ◯ No ◯

Parent/carer details:

Parent/Carer Name*		**Parent/Carer Name**	
Relationship*		**Relationship**	
Address (if different from above)*		**Address (if different from above)**	

Language Speaks/Understands*		**Language Speaks/Understands**	
Is an interpreter required?*	◯ Yes ◯ No	**If so for which language?**	
Mobile Number (of each parent)*			
Telephone Number*			
Email Address			

Gender	
Ethnicity	
Nationality	
Religion	

GP

Name:

Address:

GP Email Address:

Telephone Number:

Fax Number:

RISKS

Are there any known risks to visiting this family or home:

◯ YES ◯ NO

If Yes, please give details:

Services

Please tick/highlight all the services you are requesting

- ☐ Children's Speech and Language Therapy
- ☐ Children's Dysphagia Service (please use separate referral form for eating and drinking)
- ☐ Other (please state) _____

For preschool children with concerns about their development please refer to Blenheim Child Development Centre on a Blenheim Referral form which can be emailed to bfwh.blenheimhouse.cdc@nhs.net.
NB: SLT referrals still require the single point of access form completing.

Referrals for the following service are accepted from medical practitioners only:

- ☐ PICS- Paediatric Community Nurse
- ☐ Children's Physiotherapy
- ☐ Children's Occupational Therapy

_____

Diagnosis and reason for referral*:
For speech and language therapy referrals: please tick which areas of development you are concerned about and provide a brief summary. *Attention and listening* ☐ *Understanding language* ☐ *Expressive language* ☐ *Speech sounds* ☐ *Social interaction and play* ☐ *Stammering* ☐ *Voice difficulties* ☐

Child skills/milestones:
Please describe how the child is currently developing in relation to the identified areas of concern.

Health/Medical Information:

History:
E.g., family history in relation to concerns, any other relevant back ground information.

Current Medications:

What Advice/Treatment/Therapy/Support has already been put in place and tried:

What other professionals/Services are involved (include name and contact details):

Health Needs/ Expected Outcomes:
What are you hoping this referral will achieve/goals of child/family:

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Name*		**Organisation***	
Job Title*		**Service***	
Qualifications*		**Address***	

CONSENT

Please tick to confirm that you have:

- ☐ Discussed and agreed the contents of this referral with Parent/Person with Parental Responsibility **
- ☐ Gained verbal and/or written consent to the referral **
- ☐ Gained verbal and/or written consent to sharing of information with relevant professionals.
- ☐ Gained consent for copies of appointment letters to be sent to: Nursery/School ☐ Health Visitor ☐ Other _____

****Please note this Referral will not be accepted if this consent has not been given**

Date ……

Please send the completed PDF form back through the Trust website, or email the completed form to: bfwh.admin.paediatrictherapy@nhs.net

Please identify if this is an urgent referral within the subject line of the email.

Or send by post to:
St Annes Primary Care Centre,
Durham Avenue,
Lytham St Annes.
FY8 2EP