**DATE OF REFERRAL ……………………………………………………….**

**This form can be used to refer children to the NHS Children’s Care Coordination Team (*formerly known as Early Support*) where you feel a child would benefit from support from more than one health professional (including keyworkers, speech and language therapy, occupational therapy, physiotherapy and community paediatrics).**

**Please see** [**https://www.kentcht.nhs.uk/childrens-therapies-the-pod/care-coordination/**](https://www.kentcht.nhs.uk/childrens-therapies-the-pod/care-coordination/) **for referral criteria**

For referrals to the **Kent Portage service** please complete the Kent Portage referral form which can be found on the following page: [**https://www.kelsi.org.uk/special-education-needs/special-educational-needs/kent-portage**](https://www.kelsi.org.uk/special-education-needs/special-educational-needs/kent-portage)

*Please tick to indicate the following:*

1. **I am referring this child to the CCCT for the first time.**

Please note that the referral will not be processed if all appropriate sections of the form are not completed and consent is not obtained.

1. **This child has previously been referred to CCCT and**

**I would like to request for input from a new service.**

Please note that for re-referrals, not all of the sections on the form need to be completed as long as a recent report where applicable is attached and it is clearly outlined the desired outcome of the referral at the top of page 4 and consent is confirmed on page 6.

|  |  |  |
| --- | --- | --- |
| **Please indicate which locality you are referring to (please tick):** | | **√** |
| **Locality/Area** | Ashford |  |
| Canterbury |  |
| Dover |  |
| Shepway |  |
| Thanet |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s details** | | | |
| **Child’s name** |  | **Date of Birth** |  |
| **Age in years and months** |  |
| **NHS number** |  | **Gender (male/female)** |  |
| **Address** |  | | |
| **Postcode** |  | **Phone number** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of the referrer** | | | |
| **Name** |  | **Role** |  |
| **Agency/organisation** |  | | |
| **Email address** |  | **Phone number** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of Parent/Carer** | | | |
| **Name** |  | **Phone number** |  |
| **Relationship to child** |  | **Do they hold parental responsibility (Y/N)** |  |
| **Email address** |  | | |
| **First (or main) language used** |  | **Interpreter Required (Y/N)** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of Siblings** | | | |
| **Sibling name & DOB** |  | **Are they known to any health services? (if yes please give details)** |  |
| **Sibling name & DOB** |  | **Are they known to any health services? (if yes please give details)** |  |
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|  |  |
| --- | --- |
| **Safeguarding** | |
| **Is the child known to Social Services?** | **Y/N** |
| **Is the child a Child in Need?** | **Y/N** |
| **Is the child subject to a Child Protection Plan?** | **Y/N** |
| **Is the child a Looked after child?** | **Y/N** |
| **Local Authority with responsibility** |  |
| **Name and contact number of social worker** |  |
| **Please provide details if you have answered yes to any of above** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Education setting details (if attending)** | | | |
| **Name and address of Nursery/ Pre-school setting** |  | | |
| **Contact name** |  | | |
| **Phone number** |  | **Number of hours child attends (per week)** |  |
|  |  |  |  |

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| --- | --- |
| **Please confirm if a separate referral has been made to Kent Portage service:** | Yes  No  Date of referral: |

|  |  |
| --- | --- |
| **Please confirm if a separate referral has been made to Kent Portage service:** | Yes  No  Date of referral: |

|  |  |  |
| --- | --- | --- |
| **Professionals currently involved** | | |
| **Profession** | **Name** | **Contact details** |
| **GP** |  |  |
| **Health Visitor** |  |  |
| **Key Worker** |  |  |
| **Consultant / Paediatrician** |  |  |
| **Occupational Therapist** |  |  |
| **Physiotherapist** |  |  |
| **Speech & Language Therapist** |  |  |
| **Social Care / Worker** |  |  |
| **Specialist Teaching & Learning Service** |  |  |
| **Specialist Teaching & Learning Service HI/VI/MSI** |  |  |
| **Early Help** |  |  |
| **Other** |  |  |

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| **What is the reason for this referral? How do you think this child would benefit from CCCT?** |
|  |
| **What are the parents/carers expecting from this referral?** |
|  |
| **Have there been any delayed early milestones, such as sitting, walking and/or talking?** |
|  |
| **- What are the child’s strengths and weaknesses in each developmental area**  **- Please describe how their everyday life is impacted by the current level of functioning in each area** |
| 1. **Speech, language and communication**   **Please comment specifically on the child’s**   1. **Attention- their ability to stay at activities and listen to others** 2. **Understanding of what is happening and what is being said,** 3. **Use of actions, gestures or words to communicate** 4. **Differences in speech sounds.**   **Please give several examples of the way the child communicates and the words that they would typically use.** |
|  |
| 1. **Gross motor skills**   **e.g. sitting independently, walking, running, balance** |
|  |
| 1. **Fine motor skills**   **e.g. handling objects, ability to draw/write or help with feeding** |
|  |
| 1. **Social & emotional development**   **e.g. play with or alongside other children, ability to relate to adults, eye contact, attachment concerns** |
|  |
| 1. **Self care skills & Eating**   **e.g. dressing, cutlery skills, toileting** |
|  |
| * **Does the child demonstrate any sensory behaviours – e.g. vision, hearing, touch** * **Does the child demonstrate any repetitive or restrictive behaviours – e.g. fixed agenda, need for routine/adaptation to change, repetitive movements** |
|  |
| **Background information: Please include pregnancy/birth, past medical history, medications, relevant family history (specifically if any family history of neurodevelopmental conditions)** |
|  |
| **Please attach any relevant reports** |

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| **Parent / carer consent** |
| *The referrer when completing this referral, needs to have gained verbal consent from the parent or guarding with Parental Responsibility\* for the child/young person concerned.*   * *\*A mother automatically has parental responsibility for her child from birth.* * *In England and Wales, if the parents of a child are married to each other at the time of the birth, or if they have jointly adopted a child, then they share parental responsibility.* * *For couples who are not married: From 1 December 2003 a father shares parental responsibility if he jointly registers the birth of the child with the mother (ie he puts his name on the child’s birth certificate).* * *Parents do not lose parental responsibility if they divorce. Parental responsibility can be changed by order of the Court.*  1. **By completing this form I confirm that as the referrer I have gained verbal consent from the parent or guardian to refer this child to the Care Coordination Team.** 2. **By completing this form I confirm that as the referrer I have gained verbal consent from the parent or guardian for information to be shared between the National Health Service (NHS), Kent County Council (KCC), and other agencies as appropriate in connection with the referral.** 3. **By completing this form I confirm that as the referrer I have gained verbal consent from the parent or guarding for information to be shared between different professionals working with the family in connection with this referral, and that such professionals might include (amongst others), doctors, nurses, therapists, psychologists, social workers, portage workers, nursery staff and teachers.**   **Referrer’s name………………………………….....................................Date……………………………….** |

**Please email the completed, signed referral form securely to the appropriate administrator for the area the child resides in (see below. If you have concerns about sending information from an unsecure email address please contact the relevant team on the number below for the correct postal address.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **Contact Name/Service** | **Phone Number** | **Email Address** |
| **Ashford** | EKHUFT Community Child Health | 01233 651927 | [Ekh-tr.childhealthashford@nhs.net](mailto:Ekh-tr.childhealthashford@nhs.net) |
| **Canterbury/Coastal** | EKHUFT Community Child Health | 01227 783042 | [Ekh-tr.childhealthcanterbury@nhs.net](mailto:Ekh-tr.childhealthcanterbury@nhs.net) |
| **Dover** | EKHUFT Community Child Health | 01304 222521 | [Ekh-tr.childhealthBHD@nhs.net](mailto:Ekh-tr.childhealthBHD@nhs.net) |
| **Shepway** | EKHUFT Community Child Health | 01303 854461 | [Ekh-tr.childhealthshepway@nhs.net](mailto:Ekh-tr.childhealthshepway@nhs.net) |
| **Thanet** | EKHUFT Community Child Health | 01843235145 | Ekh-tr.childhealththanet@nhs.net |