Norfolk Community Health and Care NHS Trust

Referral to Disability, Additional and Specialist Healthcare (DASH) Community Children's Services

Form effective from 24/5/2013

SPOR, Children's Centre, 40 Upton Road, Norwich, NR4 7PA
Tel: 01603 508978 Fax: 01603 508979
Open Monday to Friday 08:45 - 17:00

Please note: All areas marked with a * are mandatory and **must** be completed.

Details of the child/young person (c/yp)					
NHS number			Referral date *		
First name *		Surname *			
Alternative name * [AKA]		Date of birth *		Age	
Current address *			Postcode *		
Contact number 1 *		Contact number 2			
Gender *	☐ Male ☐ Female ☐ Other	First language *			
Interpreter needed? *	☐ Yes / No ☐	Language			
Current Nursery/ School/ College *					

GP details			
Name of GP *		Practice name *	
Address			
Postcode		Contact number	

Referrers details				
Name of referrer *		Job title *		
Address *			Postcode *	
			Contact number *	

What service(s) are you requesting from DASH? * (please tick a service and add detail below)

☐ Community Nursing	☐ LDD Nursing	☐ Psychology	☐ Speech & Language Therapy
☐ Occupational Therapy	☐ Paediatrician	☐ Shortbreaks Homebased	☐ Shortbreaks Residential

What outcome(s) are you expecting from DASH? *

Current situation and your concerns *
Please describe what is happening, where, when and any risk factors. Please give examples, detail specific incidents and suggest the impact on physical health, education, self esteem, emotional wellbeing and relationships.

History *
Explain the background to the problem(s), are they stable or worsening, what has been tried, what has worked?

Specialist Needs
Please provide details in Additional Information section on page 4 if you answer 'yes' to any of the following

Does the c/yp have a diagnosed learning disability? *	☐ Yes / No ☐	Does the c/yp have a medical diagnosis? *	☐ Yes / No ☐
Does the child take any medication? *	☐ Yes / No ☐	Does the c/yp have any disabilities? *	☐ Yes / No ☐
Does the c/yp have a Statement of Educational Needs? *	☐ Yes / No ☐	Is the child subject to a Child Protection Plan? *	☐ Yes / No ☐
Is the c/yp looked after (i.e. under the care of the Local Authority)? *	☐ Yes / No ☐	Children's Act Section (if under LA):	
Has a Common Assessment Framework been completed? *	☐ Yes / No ☐	Framework attached?	☐ Yes / No ☐

Other Agencies/Professionals actively involved * (continue in 'Any Additional information' if required)		
Name of Agency/Professional	**Contact Name**	**Contact Number**

Any additional information? * N.B. Please include evidence of specialist needs and severity of learning disability if applicable

Awareness and agreement of child/young person *				
Is the c/yp aware? *	☐ Yes / No ☐	Is the c/yp in agreement? *	☐ Yes / No ☐	If 'No' please tick the reason below
☐ Too young ☐ Not Gillick competent ☐ Other:				

Person(s) with parental responsibility			
Person 1		**Person 2**	
First name *		First name	
Last name *		Last name	
Current address * [If different from above]		Current address [If different from above]	
Postcode *		Postcode	
Contact number *		Contact number	
Relationship to c/yp *		Relationship to c/yp	
First language *		First language	
Is an interpreter needed? *	☐ Yes / No ☐	Is an interpreter needed?	☐ Yes / No ☐

Parental responsibility consent *			
The information on this form will be used to assess the need for a service from DASH. The information may be shared with other parts of Norfolk Community Health and Care (NCH&C) and/or contact may be made to other NCH&C external agencies where necessary in order for DASH to assess the need or provide appropriate service.			
By signing this form I consent to this referral being processed for the named child and to the sharing of information contained within this form.		Date *	
Signature *		Print name *	

Allocation details - for internal use only			
Referral received at SPOR (please date stamp) *			
Internal information (please add details below if required)			
Date of allocation *		Outcome* (please add detail below)	☐ Accepted ☐ Rejected
Accepted			
Referral type	☐ Routine ☐ Soon (6-8 weeks) ☐ Urgent (within 48hrs)	Service offered	
		Team/Caseload	
Rejected/ Refer to other service			
Please provide a detailed reason for the rejection			
Refer to			

SPOR – for internal use only				
Tick when complete:	☐ PAS	☐ SystmOne	☐ Scanning	☐ Added to Waiting List

Paediatric Consultant Appointments - for internal use only			
Appointment date		Appointment time	
Location/Clinic			
Consultant name			