Bridgewater Community Healthcare NHS
NHS Trust

WARRINGTON
Borough Council

CHILDREN 4 YEARS and UNDER COMPLEX CASE REFERRAL FORM

(If a Child only needs a single health agency then use that agency professional referral form)

Child's name _____ Male / Female_____ D.O.B_____

Address _____

Postcode _____ NHS Number _____ GP Name_____

Child's Ethnicity _____ Is this child on a care pathway? Yes / No / Unknown

Nursery / Playgroup / Preschool name _____

Parent / Guardian full name_____ Tel: _____ Mob_____

Does this Parent / Carer have any disabilities that we need to consider for appointments?

Main language spoken in the home _____ Interpreter needed Yes / No

Please list the names and details of all children and adults who are currently residing with this child:

Surname	First Name	DOB	Relationship to child

Please list all other professionals already involved with this child.

Professional	Name	Phone number	Base

Referrers Printed Name: _____ Profession: _____

Base: _____ Contact No: _____ Date: _____

Form issued: Sept 2013

PARENTAL / CARER CONSENT FOR REFERRAL TO COMPLEX CASE PANEL

Signed consent is ideal, verbal consent is acceptable

- I had the reasons for the referral explained and I am happy for my child to be considered for assessment
- I understand that information gathering and sharing is beneficial for my child and that information recorded about my child and family may be shared with other agencies and used for the purpose of providing services for my child.
- I understand that this referral will be discussed at a meeting of Professionals in order for them to work together to provide the support that is best suited to my child's needs.
- I am aware that I may limit the information shared and that I may withdraw my consent at any time. I do not want the information to be shared with ……..
- I understand that I am expected to attend appointments and to carry out recommendations at home as advised by the clinicians.
- I am aware that if another adult brings my child to sessions they will receive all information about my child unless I inform the services otherwise
- I confirm that I understand if this referral is accepted a link worker will contact me to arrange an appointment
- I understand that if my child's needs are not best met via the Complex Case Panel this form will be returned to the referrer for them to provide future support.

Signature: _____ **Date:** _____

Print name: _____ **Relationship to child:** _____

Verbal consent obtained from: _____ **Relationship to child:** _____

What has the referrer done to support the family up to now? What has worked well and what has not worked as well?
What do Parents / Carers wish to happen as a result of this referral?
Does this child have a CAF / Family Support Plan? Circle **Yes** **No** **Unknown** **If Yes please attach**

Please complete all sections **DEVELOPMENT, COMMUNICATION AND PLAY**

Indicators of concern	Tick yes	no	unknown
1. Child appears to be losing skills at any age	☐	☐	☐
2. Child has a diagnosed syndrome	☐	☐	☐
3. Child has abnormal eye movement, fixating on objects or not tracking moving objects	☐	☐	☐
4. Child is very quiet at 9 months, has no babble or makes a very limited range of sounds	☐	☐	☐
5. Child has very limited interaction by 18 months eg child does not point or make requests by pointing or showing. Child may often seem "in a world of their own"	☐	☐	☐
6. Child is not able to point to at least 1 body part (eg nose, hair by 18 months)	☐	☐	☐
7. Child is not able to select at least 3 familiar objects from a small choice by 21 months	☐	☐	☐
8. Child communicates mainly on his / her own terms at 24 months and beyond ie *mostly* to ask for items. It is very difficult to draw child's attention to things.	☐	☐	☐
9. Child mouths or bangs toys together rather than using toys to pretend by 24 months (e.g. putting a hairbrush in their mouth rather than brushing their own hair)	☐	☐	☐
10. Child is not able to play with toys in a pretend way by 30 months ie cannot pretend to brush mum's hair or feed a toy	☐	☐	☐
11. Child has unusual or obsessive interests in particular types of play by 30 months and beyond (e.g. lining toys up, excessive spinning of toys, special interest in washing machines or other electrical equipment)	☐	☐	☐
12. Child cannot follow instructions such as **Where's Mummy's hair? Where's child's shoes?** by 30 months (with no adult gestures or pointing to cue understanding)	☐	☐	☐
13. Child has poor social interaction	☐	☐	☐
14. Child cannot have a conversation by 42 months or repeats what you say rather than responding	☐	☐	☐
15. Child appears to have inappropriate reactions / behaviour to sensory input	☐	☐	☐

Any significant family history relevant to the referral or other information / concerns or observations to support your referral please add below

If there are concerns about other aspects of communication not listed above please refer to the single agency Speech and Language Therapy referral form

Please complete all sections **MOBILITY AND MOVEMENT – Gross motor skills**

Indicators of concern	Tick yes / no / unknown		
16. Child from birth demonstrates asymmetry in movement eg arm / leg / head	☐	☐	☐
17. Child from 6 weeks appears excessively stiff or excessively floppy eg head / body	☐	☐	☐
18. Child is not sitting independently by 9 months	☐	☐	☐
19. Child is not moving around on the floor by 12 months	☐	☐	☐
20. Child is not walking independently by 24 months	☐	☐	☐
21. Child shows reduced co-ordination / delay in jumping, running, balance skills by 4 years of age	☐	☐	☐

Any other information / concerns or observations to support your referral please add below

If there are concerns about bow legs, knock knees, flat feet or other aspects of mobility please refer to single agency Physiotherapy referral form

Please complete all sections **FUNCTIONAL SKILLS**

Indicators of concern	Tick yes / no / unknown		
22. Child is unable to grasp and release objects by 6-9 months	☐	☐	☐
23. Child is unable to grasp objects using thumb and index finger by 12 months	☐	☐	☐
24. Child has movement difficulties and lacks awareness of / neglects a limb at 12 months	☐	☐	☐
25. Child is unable to manipulate small objects by 3 years of age	☐	☐	☐
26. Child has great difficulty with self care such as:			
27. Feeding with finger or spoon by 18 months	☐	☐	☐
28. Drinking from a cup by 2 years	☐	☐	☐
29. Pulling clothes on / up by 3 years	☐	☐	☐
30. Child is unable to sit in a chair unsupported by 3 years	☐	☐	☐
31. Child is likely to require additional support when they start school	☐	☐	☐

Any other information / concerns or observations to support your referral please add

Please complete all sections

MECHANICAL SWALLOWING DIFFICULTIES

You will need to have observed the child eating and drinking

Indicators of concern	Tick yes / no / unknown		
32. Child displays uncoordinated swallow resulting in coughing or choking	☐	☐	☐
33. Child displays repeated throat clearance, eye watering or facial reddening at mealtimes	☐	☐	☐
34. Child displays wheezing or "gurgly" sounds around mealtime	☐	☐	☐
35. Child has a history of failure to thrive, chest infections or may be having treatment for asthma or cyanotic episodes	☐	☐	☐

If the child is vomiting and refusing food please refer to GP or Hospital Paediatrician for medical investigation or support to manage gastro oesophageal reflux.

If the child requires support for weaning or can manage a range of foods but prefers to eat a limited range of tastes please refer to Health Visitor / School Health Advisor as these are unlikely to be mechanical issues.

PEN PORTRAIT; please describe the child's strengths and challenges they face. What is the impact on their daily lives? Please include a pen portrait from Parents / Carers if they would like to contribute one

Return referral to: Referrals, Child Development Centre, Sandy Lane, Warrington, WA2 9HY

Phone number: 01925 867867

OFFICE USE ONLY

Date presented to the under 4s Complex Care Panel: _____
Decision: Accept / Return to referrer /Other

Action	By whom	By when
1		
2		
3		
4		
5		

Signed: _____

Actions to be reviewed by _____ on _____ date