

**Referral Form:**

**Rehabilitation and Behavioural Assessments**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Referring Clinician: | | | | | Referral for child or young person: | |
| Name |  | | | | Name |  |
| Address |  | | | | DOB |  |
| Address |  | | | | NHS number |  |
| Post Code |  | | | | Hospital number |  |
| Telephone |  | | | | Is this referral for a child looked after?  Yes  No | |
| Email |  | | | |
| Date |  | | | |
| Parent/Carer | | | | |  | |
| Name |  | | | | Who has parental responsibility? | |
| Address |  | | | |
| Address |  | | | |
| Post Code |  | | | | Are parents in agreement with the referral?  Yes  No | |
| Telephone |  | | | |
| Email |  | | | |
| Reason for referral | | | | | | |
| Rehabilitation – Post Surgery  Rehabilitation – ABI  Rehabilitation – Other  Behavioural Assessment | | |  | |  | |
| **Clinical aims and desired outcome of referral** | | | | |  | |
| **Parental aims and desired outcome of referral** | | | | |  | |
| **Diagnosis** | | | | |  | |
| **Equipment requirements** | | | | |  | |
| **Current medication**  *Please include the name, strength, dose of medications* | | | | |  | |
| **Past medication**  *Please include the name, strength, dose of medications* | | | | |  | |
| Background History – please include/attach relevant current and historical clinic letters/reports and investigations (EEG, MRI, Genetics) | | | | | | |
|  | | | | | | |
| Hospital Admissions – please include any emergency/significant stays in hospital | | | | | | |
|  | | | | | | |
| Other services involved with child or young person | | | | | | |
| CAMHS  Respite  Social Services  Care Order? | |  | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Other professionals involved or previously seen: | | | | | | | | | | | | | |
| Professional |  | Name and address | | | | | | | | Date last seen | | | |
| Neurologist |  |  | | | | | | | |  | | | |
| Neurosurgeon |  |  | | | | | | | |  | | | |
| Psychiatrist |  |  | | | | | | | |  | | | |
| Psychology |  |  | | | | | | | |  | | | |
| Physiotherapy |  |  | | | | | | | |  | | | |
| Occupational  Therapy |  |  | | | | | | | |  | | | |
| Speech and Language Therapy |  |  | | | | | | | |  | | | |
| Other |  |  | | | | | | | |  | | | |
| School provision – is the child or young person currently in full time education? If not please provide details. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Child or adult protection concerns. Have there been any pervious child or adult protection concerns that Young Epilepsy need to be aware of to support the child or young person effectively and manage risk? | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Are there any concerns related to any of the following areas and the child/young person named above? | | | | | | | | | | | | | |
| Self-harm or  Self-Injurious-Behaviour | | | |  | Suicidal ideation | |  | | Substance misuse  - Parent/carer  - Child/young person | | |  | |
| Previous abuse or allegations of abuse | | | |  | Offending history | |  | | Disability  - Parent/carer or  - Child/young person | | |  | |
| Going missing | | | |  | Challenging physical behaviour | |  | | Mental Ill Health  - Parent  - Child/young person | | |  | |
| Living in care | | | |  | Young carer | |  | | Finance concerns | | |  | |
| Housing concerns | | | |  | Health concerns | |  | | Other | | | | |
| **If any of the above areas are identified, please complete the following in order to identify and manage the risks** | | | | | | | | | | | | | |
| Area of risk as per above categories | | | Description of risk | | | Risk H/M/L | | Risk Management Actions | | | Revised Risk  H/M/L | |
|  | | |  | | |  | |  | | |  | |
|  | | |  | | |  | |  | | |  | |
|  | | |  | | |  | |  | | |  | |
|  | | |  | | |  | |  | | |  | |
|  | | |  | | |  | |  | | |  | |
| **Has funding been agreed in principle?** | | | | | | | | | | | | | |
| Yes  No  - If yes, please attach a copy of the funding agreement | | | | | | | | | | | | | |
| **Please use this box for any other relevant information you feel may be helpful.** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Please return the completed form and relevant information to:** | | | | | | | | | | | | | |
| Assessment and Rehabilitation Manager  Young Epilepsy, Neville Centre, St Piers Lane, Lingfield, Surrey, RH7 6PW  [youngepilepsy.healthservices@nhs.net](mailto:youngepilepsy.healthservices@nhs.net) 01342 832243 | | | | | | | | | | | | | |