

Bath and North East Somerset Single Point of Entry Referral Form

<p>This form is also available as a Word template.</p> <p>Please contact the SPE administrator if you would like a copy of this.</p>	 	<p>Please return this form, completed as fully as possible, to:</p> <p>SPE Administrator Child Health Department, Ground Floor Midford House, St Martin's Hospital Kempthorne Lane Bath BA2 5RP vcl.bathnescliniccoordinatorteam@nhs.net Tel: 01225 731 548</p>
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Details of Child Or attach label. Leave this section blank if these details are on an accompanying letter.

Child's Surname: <Patient name> Forenames <Patient name>

Date of Birth <Date of birth>

Family name if different to child's _____

NHS No <NHS number> Please tick box if interpreter is needed.

Ethnicity <Ethnicity> First language <Main spoken language>

Please tick box if interpreter is required, if yes what language _____

Address <Patient address>

Post code <Patient address> School / Pre-School <Patient School>

Mobile <Patient contact details> Home telephone <Patient contact details> Preferred telephone <Patient contact details>

Child's GP <GP name> <GP details>

Health Visitor/school nurse (if known)

Referral to:

These are the teams currently accepting referrals through the B&NES Single Point of Entry System.
 If you are not sure where your referral should go, please refer to the Intake Team.
 A team of clinicians will discuss the referral and ensure it is passed to an appropriate team.

Referrals from Schools: Please ensure you discuss your referral with the school nurse or educational psychologist. They may be able to help the child, seeking advice from professionals within the locality team, without the need for a full referral. Discussed with school nurse / educational psychologist? Yes No

<input type="checkbox"/> Paediatrician <input type="checkbox"/> CAMHS (check new referral criteria) <input type="checkbox"/> Speech and Language Therapy <input type="checkbox"/> Children's Learning Disability <input type="checkbox"/> Nursing Service	<input type="checkbox"/> - Continence Service <input type="checkbox"/> Dietician <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> School Nursing Service
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Audiology

Orthoptist

Intake Team

The referrer

Why are you making this referral?

Please give as much information as possible to enable locality professionals to make the best possible decision.

Continue on another sheet if needed or attach a letter.

Please send copies of additional information/reports as appropriate.

Child/young person

What do you want to happen as a result of this referral?

Parents/Carers

What do you want to happen as a result of this referral?

This service is provided by Virgin Care, NHS Bath and North East Somerset CCG and Bath and North East Somerset Council.
Registered office: Virgin Care Limited, Lynton House, 7-12 Tavistock Square, London WC1H 9LT
Registered in England and Wales number: 5466033

Service provided by



About the parents/carers			
Name	Relationship	Contact details	Parental Responsibility
			<input type="checkbox"/> yes <input type="checkbox"/> no
			<input type="checkbox"/> yes <input type="checkbox"/> no

Please indicate which of these services are, or have been, involved with this child.

Education Welfare Social Services Health Visitor
 Educational Psychology Vision Youth Offending Team
 Behaviour Support Services Inclusion/Learning Support Connexions
 Other
please specify _____

For each agency currently working with the child/young person/family please provide the following details.
Use 2nd sheet if necessary.

Start date	Agency	Name and Role	Tel Contact Nos

Important no referral can be accepted without the consent of the child or parent/guardian.

Please tick at least one box.

The child or parent/guardian has consented to this referral. Child Parent/Guardian

I have discussed the referral fully with the child/parent/guardian as appropriate, making it clear that any referral to more than one team, or to the Intake Team, will be discussed by a team of clinicians before allocation.

Discussed with GP Yes No

Signed _____ Job Title _____

Print Name _____ Date _____

Location _____ Contact no _____

Office use only

Entered on system _____ on: _____

For uniprofessional assessment, forward to _____ on: _____

Discussed at Intake Team meeting _____ on: _____

Decision: _____ forwarded to: _____ on: _____

On call Dr _____ Please indicate Community Paediatrician _____

_____ or RUH Paediatrician