**Referral Guidance**

* Please note this form is to be used for a referral to Developmental Paediatrics for concerns about developmental delay or for children under the age of 6 years with concerns about ASD and ADHD
* The service will only accept referrals for the ages of 0-16
* Please note there are separate referral forms for children and young people aged 6 and over where there are concerns of ASD and/or ADHD available on the Alder Hey website
* Please note in order for the Developmental Paediatric service to be able to start the assessment process, the referral form needs to be completed in its entirety
* You can submit this form either electronically by saving it into a PDF format and email it over to our Booking & Scheduling team refertoalderhey@nhs.net
* Or by post to the following address: Referrals, Alder Hey Children’s NHS Foundation Trust, Eaton Road, L12 2AP
* Please note we accepts referrals from GP’s, School, Health & Social Care or any other named or appropriate professional working with the Child or Young Person
* All referrals will need to be generated in partnership with the Child or Young Person’s parent or carer; school with the support of Teachers and Special Educational Needs Coordinators. For those children who are Elective Home Educated, please liaise with the appointed EHE School Nurse
* For the best outcome for the Child or Young Person, the form should be completed by a person who knows the child well and sees them on a regular basis
* Please note if the evidence is not received in totality or does not meet our referral criteria we will be unable to progress with the referral and the referral will be rejected
* For further guidance on completing this form, please email CommPaedsQueries@alderhey.nhs.uk
* Upon review of the referral form, we will either accept the referral or contact the referrer to outline reasons the referral was not accepted and suggest an alternative route/service
* Referrer, parent/guardian, GP and school nurse team will be copied into all correspondence

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| **Developmental Paediatric Referral**  |
| **Date:** |
| **Patient Details** | NHS No / AH number if known |  |
| **Name** |  |
| **DOB** |  | **Age** |  | **Gender** |  |
| Address |  |
| **Postcode** |  | **Telephone** |  |
| **Language ( if not English)** |  | **Translator Needed** |[ ]
| **Parent/Carer Email Address** |  |
| **Does the Parent/Carer have readily available internet access in a private setting?***N.B. Parts of our assessment service will endeavour to use virtual appointments; however, we can accommodate alternative arrangements if these are not possible* | Yes[ ]  | No[ ]  |
| **Do any of these apply:** | **Looked After Child**[ ]  | **Child Protection Plan**[ ]  | **Child in Need**[ ]  |
| **School/Nursery** |  |
| **Reason for Referral** |
| **Neurodevelopmental Behaviour Disorder – Concerns regarding the possibility of:** |
| Neurodevelopmental Disorder [ ]  | Learning Difficulties [ ]  |
| Social Communication Concerns (age under 6)[ ]  |  |
| **Neurodisability – Concerns regarding the possibility of:** |
| Cerebral Palsy [ ]  | Genetic syndrome[ ]  | Developmental Delay [ ]  | Other[ ]  |
| **History of concern (if other, please state why a developmental paediatric opinion is suitable)**i.e. ASD – Difficulties with social communication/interaction and rigidity of thought and behaviour in more than one setting. |
| **Other agencies involved** | EHAT/Early Help [ ]  | CAMHS [ ]  | Speech and Language [ ]  |
|  | Physiotherapy [ ]  | Occupational Therapy [ ]  | Social Services [ ]  |
|  |  Other (please specify) |
|  |
| GP Name |  | Practice Name |  |
| Address |  |
| Postcode |  | Telephone |  |
|  |
| **Referrer Details if not GP** |
| Name |  | Role |  |
| Address |  |
| Postcode |  | Telephone |  |
| Email address |  |

**Alder Hey Developmental Paediatrics Referral**

*Please be aware that all children under 6 years of age should* ***ideally*** *have an EHAT open and should have had two Team Around the Family (TAF) meetings before a referral to ASD Pathway is completed. If not please provide evidence of support/interventions and family engagement in services prior to referral such as Children’s Centres; Children’s Services.*

Please provide as much information as you can and attach any relevant reports that will support the referral. This information can be completed by any professional who knows the child well, but we will not be able to proceed with the referral unless this information is completed.

**Child’s Name** ………………………………………………………………….  **DOB:** …………………………………….

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| **Social Interaction and Reciprocal Communication:** | **Please Tick** |
| **Spoken Language** | Non-speech like vocalisation  | [ ]  |
| Odd or flat intonation | [ ]  |
| Frequent repetition of set words and phrases (echolalia) | [ ]  |
| Reduced or infrequent use of language  | [ ]  |
| **Seen in children above 5 years:**Monotonous tone | [ ]  |
| Talking ‘at’ others rather than two way conversation | [ ]  |
| Responses to others can seem rude or inappropriate | [ ]  |
| **Responding to****Others** | Absent or delayed response to name | [ ]  |
| Reduced or absent social smiling | [ ]  |
| Unusually negative response to others’ requests | [ ]  |
| **Seen in children above 5 years:**Subtle difficulty in understanding others intentions | [ ]  |
| Few close friends or reciprocal relationships  | [ ]  |
| Social isolation | [ ]  |
| **Interacting with Others** | Reduced or absent awareness of personal space; unusually intolerant of others entering their personal space | [ ]  |
| Reduced or absent social interest in others  | [ ]  |
| Reduced or absent social play with others | [ ]  |
| **Seen in children above 5 years:**Reduced or absent awareness of socially expected behaviour | [ ]  |
| **Eye Contact and Gestures** | Absent or reduced use of social eye contact | [ ]  |
| Reduced or poorly integrated gestures and facial expressions | [ ]  |
| Reduced or absent joint attention (i.e. following a point, using a point at or showing objects to share interests, gaze switching) | [ ]  |
| **Ideas and Imagination** | Reduced or absent imagination and variety of pretend play | [ ]  |
| **Seen in children above 5 years:**Reduced or absent flexible imaginative play or creativity, although scenes from media may be may be re-enacted | [ ]  |
| **Unusual/Restricted Interests and/or Rigid and** **Repetitive** **Behaviours** | Repetitive ‘stereotypical’ movements (i.e. hand flapping,body rocking, spinning, finger flicking) | [ ]  |
| Repetitive or stereotyped play  | [ ]  |
| Insistence on following own agenda | [ ]  |
| Extremes of emotional reactivity to change in new situations, insistence on things being ‘the same’ | [ ]  |
| Over or under reaction to sensory stimuli  | [ ]  |
| **Seen in children above 5 years:**Rigid expectation that other children should adhere to rules of play | [ ]  |
| Dislike of change, which often leads of anxiety or other forms of distress | [ ]  |
| Highly repetitive behaviours or rituals that negatively affect the young person’s daily activities  | ☐ |
| **Other** | Unusual profile of skills or deficits (e.g. social or motor coordination skills poorly developed, while particular areas of knowledge, reading or vocabulary skills are advanced for chronological age  | [ ]  |
| **Please detail any further relevant information or descriptions of behaviour(s) causing concern:** |
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| **Has an Early Help Assessment Tool (EHAT) or similar been opened?** YES [ ]  NO [ ] *(If YES please attached copies of EHAT and reviews.* *To check if an EHAT is in place please contact 0151 233 5772.**If NO please provide evidence of support/interventions offered)***Has a Team around the Family meeting been organised?**YES ☐ NO ☐*(If yes please attached copies of TAFs meetings or date of first meeting)* **Information and support provided by school (Graduated Approach)** YES [ ]  NO [ ] *(If yes please attached information of last two review meetings)***Please detail any concerns/information from school regarding the child/young person**: **Are you aware of any previous or current safeguarding concerns?** *If YES please provide more information below:**Please be aware that all children under 5 years of age should* ***ideally*** *have an EHAT open and should have two TAFs meeting before a referral to ASD Pathway is completed.**If not please provide evidence of support/interventions and family engagement in services prior to referral such as Children’s Centres; Children’s Services.* |

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| **What is the Child’s/Young Person’s preferred form of communication?**  | Spoken Language  | YES [ ]  NO [ ]  N/A [ ]  |
| Written Language  | YES [ ]  NO [ ]  N/A [ ]  |
| Signing (what type? e.g. Makaton)……………………………………………………. | YES [ ]  NO [ ]  N/A [ ]  |
| Symbols | YES [ ]  NO [ ]  N/A [ ]  |
| PECS | YES [ ]  NO [ ]  N/A [ ]  |
| Photos/pictures | YES [ ]  NO [ ]  N/A [ ]  |
| Other: |
| **Do Parent/Carers have any specific requirements/needs that we need to be aware of?** *If YES, please describe them below.* | YES [ ]  NO [ ]  N/A [ ]  |

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| **Additional information** |
| Have the family been involved with or signposted to **ADDvanced Solution Community or any other support network**? | YES [ ]  NO [ ]  |
| *If* ***YES*** *have appointments been kept? What strategies have been used and how have they impacted? What changes have happened?* |
| Have the family been involved with or signposted to **the Liverpool ASD Training Team in Liverpool or the ASD Community Service in Sefton for pre-referral support**?  | YES [ ]  NO [ ]  |
| *If* ***YES*** *have appointments been kept? What strategies have been used and how have they impacted? What changes have happened?* |
| Have the family been involved with or signposted to either **Liverpool or Sefton Parent and Carer Forums?** | YES [ ]  NO [ ]  |
| *If* ***YES*** *have appointments been kept?* *What support has been used and how have they impacted?*  |
| Have the family been involved with or signposted to **the Isabella Trust**?  | YES [ ]  NO [ ]  |
| *If* ***YES*** *have appointments been kept?* *What strategies have been used and how have they impacted?* *What changes have happened?* |
| Has the Child / Young Person been referred to/known to **the Speech and Language Therapy Service**? | YES [ ]  NO [ ]  |
| *If* ***YES*** *have appointments been kept?* *What strategies have been used and how have they impacted?* *What changes have happened? Please attach any reports if you have them available.* |
| Has the Child / Young Person been referred to/known to **the Occupational Therapy or Physiotherapy Service**? | YES [ ]  NO [ ]  |
| *If* ***YES*** *have appointments been kept?* *What strategies have been used and how have they impacted?* *What changes have happened? Please attach any reports if you have them available.* |
| Has the Child / Young Person/ Family been referred to/known to **Mental Health or Psychotherapy Service**? (e.g. CAMHS, YPAS) | YES [ ]  NO [ ]  |
| *If* ***YES*** *have appointments been kept?* *What strategies have been used and how have they impacted?* *What changes have happened? Please attach any reports if you have them available.* |
| Has **any other support been** offered to the Child/Young Person/Family in relation to behaviour(s) causing concern from other services for example Educational Psychology Service | YES [ ]  NO [ ]  |
| *If* ***YES*** *please list the services involved. Have appointments been kept?* *What strategies have been used and how have they impacted?* *What changes have happened?* *Please attach any reports if you have them available.* |

Alder Hey Developmental Paediatric Service

**Parent/Carer Consent Form**

I/We (print parent’s name) ……..…………………………….............

Parent/carer of (print child’s name) ……..……………………....................

I understand that my/our child has been referred to the Developmental Paediatrics Service and this referral has been fully explained to me/us.

I/We give permission for the Alder Hey Developmental Paediatrics Pathway to undertake assessments as appropriate. Permission is also given to gather, discuss & share applicable information in respect to my/our child’s assessment within the team & appropriate outside agencies. Where applicable, this may include:

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| --- | --- |
| School and SENCO; including School observations | Speech and Language Therapy Service |
| Clinical Psychology | Health Visitor/School Nurse |
| Paediatrician | Social Worker, Social Services |
| Educational Psychology Service | Child and Adolescent Mental Health Services  |
| GP | Learning Disability Team |
| Alder Hey/Hospital Contact | ASD Training Team |
| Occupational Therapy Service  | Other e.g. Children’s Centre, Children’s Services |

I/We understand that information concerning risk of harm to a child or young person must always be shared for safeguarding reasons.

This form has been fully explained to me.

I can confirm I have read the above and give my consent as legal guardian.

Name of person with parental responsibility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Any other comments: |
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Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Before sending the referral to the Alder Hey Developmental Paediatrics Team please ensure that you are submitting the correct information as listed below:

**Check list**

* The Child has Liverpool or Sefton GP YES [ ]  NO [ ]
* Copies of any EHAT, TAF meetings, SEND Graduated Approach or any evidence of support /interventions offered and family engagement have been attached YES [ ]  NO [ ]
* The referral includes information from school YES [ ]  NO [ ]
* The Additional Information section has been completed YES [ ]  NO [ ]
* The consent form has been signed and attached to this referral YES [ ]  NO [ ]

**Please be aware that the Alder Hey Developmental Paediatrics Pathway is not able to accept incomplete referral forms. If insufficient information is submitted or there is lack of evidence of engagement with local support services, the referral will be rejected and returned back to the referrer.**

***We will try to accommodate any additional needs for the child or the parents/ carers where possible.***

**Support Agencies**

**Please note that there is more information around support on our website.** [Developmental Paediatrics :: Alder Hey Children's Hospital Trust](https://alderhey.nhs.uk/services/developmental-paediatrics)

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| **Liverpool Specific** | **Sefton Specific** |
| **SENDIASS** Tel. 0800 0129066**Liverpool ASD Training Team** **asdtrainingteam@liverpool.gov.uk**Tel. 0151 233 5988**The Isabella Trust**Tel. 07956 749 774**LivPaC (Parent Carer Forum)**Tel.0151 7275271, 07504 544638**SEND local offer**<https://fsd.liverpool.gov.uk/kb5/liverpool/fsd/localoffer.page> | **SENDIASS**Tel. 0151 934 3334**Autism and Social Communication Team**Tel. 0151 934 2347**The Isabella Trust** Tel. 07956 749 774**Sefton Parent Carer Forum,** **seftonparentcarerforum@gmail.com**Tel.07541 326860**SEND local offer**[**https://www.seftondirectory.com/kb5/sefton/directory/localoffer.page?localofferchannel=0**](https://www.seftondirectory.com/kb5/sefton/directory/localoffer.page?localofferchannel=0) |
| **CAMHS - Tel. 0151 293 3662 (Mon-Fri 9am – 5pm)****YPAS - Tel. 0151 707 1025** **ADDvanced Solutions Community Network -** Tel. 0151 486 1788**CAMHS Crisis Line -** Tel. 0151 293 3577 (Mon-Fri 8am to 8pm and on weekends/Bank Holidays from 10am – 4pm) |