|  |
| --- |
| **SPOT (Speech, Physiotherapy and Occupational Therapy) Service**Combined development assessment for children aged under 3 years living in Sefton requiring more than one therapy service |
| **Please complete all sections – incomplete referral forms will be returned** |

|  |
| --- |
| **PATIENT INFORMATION** |
| Name:Address:Post Code: Date of Birth:Tel / Mobile No:Email: Gender: NHS No (if known): | GP Name:Address: |
| Health Visitor:Contact Number: |
| Name of Nursery if attending:Sessions attended: |
| Ethnicity: | Language:Interpreter required?  |
| **OTHER INFORMATION** | **COMMENTS** |
| Name of Parents / Carers: |  |
| Who has parental responsibility? Consent for referral? **Yes/ No** |
| Is this a Looked After Child (LAC) **Yes/No** |
| Family Structure: |
| Professionals already involved: |
| Identified risk: e.g. Domestic violence, known infections e.g. Measles, MRSA |
| Is the child subject to: A Child Protection Plan **Yes/No** | A Child in Need Plan **Yes/No** | A Common Assessment Framework **Yes/No** |
| **REFERRER’S DETAILS** |
| Name: Designation: |
| Address:Postcode: |
| Contact Telephone No: Date:  |
| Referrer’s Signature: Email: |
| **By completing this form, you are making a request for a SPOT assessment. All referrals are centrally processed and a decision to accept this referral will be made according to the nature of the child’s difficulties and the impact this is having on their daily life. All sections of this form MUST be completed or it will be returned. Referrals must be discussed and agreed with parent/carer** |

|  |
| --- |
| **SPOT (Speech, Physiotherapy and Occupational Therapy) Service** |
| Name: DOB: NHS No:  |
|  |
| Birth History and General Development: |
| What are the concerns that you would like help with?**Please give examples of WHO is concerned and HOW the problems make it harder or stop the child doing something they want or need to do e.g. How does it affect the child’s daily life?**  |
| How concerned are you? (rate the level of concern and add any comments)Referrer- **Not at all/ a little/ a lo**t Parent- **Not at all/ a little/ a lot**   |
| Diagnosis, if known:  |
| **DEVELOPMENTAL SKILLS** | **COMMENTS** |
| Gross Motor Skills |  |
| Fine Motor |  |
| Play and Communication |  |
| Eating and Drinking |  |
| Other Concerns e.g. behaviours/ sleep etc.  |  |
| Tell us about how the child’s current level of functioning affects them:At home-In nursery- |
| What opportunities have the family/ nursery provided to help support the child’s development?What has worked well? Give examples of changes |
| How do you think the SPOT team could help the child?  |
| Is there any other information about the child/ family life you consider relevant? |
| **Please return the form to:** **seftoncommunity.physio-ot@nhs.net** |
| **South Sefton** – L20 , L21, L22, L23, L30, L31, L10, L382nd Floor, Sefton Carers Centre27-37 South RoadWaterloo, Liverpool, L22 5PETel: 0151 252 5729 | **North Sefton** L37, PR8, PR9Ainsdale Centre for Health and Wellbeing164 Sandbrook RoadAinsdale, Southport, PR8 3RWTel**:** 01704 395895  |