# SUFFOLK COMMUNITY SERVICES
# INTEGRATED COMMUNITY PAEDIATRIC SERVICES (ICPS) REFERRAL FORM

**All referrals must be directed to the Care Co-ordination Centre (preferably typed):**

| | |
|---|---|
|  | suffolk.ccc@esneft.nhs.uk |
|  | Care Co-ordination Centre, Constantine House, Constantine Road, Ipswich, IP1 2DH |
| ☎ | 0300 123 2425 |

**Only one form to be completed regardless of number of services required (tick relevant boxes below).**
**Incomplete referral forms and those with insufficient information will be returned.**

| **Patient Details** | **Parents/carers details:** |
|---|---|
| **Name:**<br><br>**NHS No:**<br><br>**Home Address (Primary):**<br><br>**D.O.B:** **Sex: M** ☐ **F** ☐<br><br>**Educational Setting:**<br><br>**GP Surgery:** | **Name/s:**<br><br>**Home Tel No:**<br><br>**Work Tel No(s):**<br><br>**Mobile(s):** |
| **Referrer details** | |
| **Name:**<br><br>**Designation:** | **Tel No:**<br><br>**Address:** |

**Service/s Required**

*Please refer to Referrals guidance and tick relevant box/boxes.*

**Paediatric Medical Services** ☐ **Audiology** ☐ **Speech and Language Therapy (SLT)** ☐

**Physiotherapy (PT)** ☐ **Occupational Therapy (OT)** ☐ **Community Children's Nursing (CCN)*** ☐

**Please phone the CCN Team directly if the referral is urgent*

**Reason for Referral**

*Please include full details. Refer to guidance (on SCH website). Additional information may be required.*
*Please note all referrals will be triaged by a senior clinician and response times/urgency assigned according to priority.*

**Relevant Past Medical History** (if known):

**Social History/Safeguarding Concerns / CAF / TAC / Child in Care** (including any special considerations/issues to be aware of when visiting)**:**

**Name and contact details of social worker involved:**

**Please attach relevant information/reports/investigations, and list below**
(including discharge summaries when transferring from hospital care)**:**

**Copy of prescription chart attached if relevant (CCN/Medical referrals only) YES ☐ NO ☐**

**Supplies sent with family (post d/c - CCN/Medical referrals only) YES ☐ NO ☐**

**Date and result of last hearing test (where relevant):**

**NB:** *Any observation of discharge, perforation or occluding wax (after treatment) should be referred directly to ENT.*

**Please explain the impact of this problem on the child/young person's daily life:**

**Please outline any strategies that have been used to help the child/young person and whether these have been successful:**

**Other Agencies/ Professionals involved with this child / young person, i.e. Consultant(s)/Health Visitor/Social Worker/Dietician:**

**Child's first language:**

**Parent/Carer's first language:**

**INTERPRETER REQUIRED YES ☐ NO ☐**

**Consent:** *Please sign below to indicate that you have explained this referral to the young person/parents/carers and that you have gained their consent for an assessment if the referral is accepted.*

**Signature/GMC Number:**

**Date:**