

# INDIVIDUAL NEEDS REFERRAL FORM



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Name of Child					
Date of Birth		Sex (M/F)			
Home Address					
Nationality		Religion		Ethnic origin	
Referred By		Referral Date			

Parents / Guardians living at child's home address						
Relationship to Child						
Title						
Forenames						
Surname						
Daytime Tel No						
Mobile Tel No						
Email Address						
Preferred contact method	PHONE <input type="checkbox"/>	EMAIL <input type="checkbox"/>	POST <input type="checkbox"/>	PHONE <input type="checkbox"/>	EMAIL <input type="checkbox"/>	POST <input type="checkbox"/>

DIAGNOSIS, CONDITION MEDICAL & OTHER SUPPORT NEEDS	
<p>What diagnosis, condition, medical needs or additional support needs does the child you care for have?</p> <p>Please write as much information as possible to describe your child's support needs in detail.</p>	

PLEASE SELECT ANY OF THE BELOW THAT IS APPLICABLE TO THE CHILD YOU CARE FOR:		
<input type="checkbox"/> Progressive/Chronic Illness <u>Technology Dependent</u> <input type="checkbox"/> Ventilator, trachy etc <input type="checkbox"/> Feeding pump <input type="checkbox"/> Intrathecal Baclofen or similar <input type="checkbox"/> Oxygen Dependent <input type="checkbox"/> Medication Dependent <input type="checkbox"/> Physical Disability	<input type="checkbox"/> Seizures <u>Feeding</u> <input type="checkbox"/> NG Tube <input type="checkbox"/> Button e.g. Gastrostomy <u>Disability Aids</u> <input type="checkbox"/> Wheelchair Dependent <input type="checkbox"/> Orthosis e.g. foot, spinal <input type="checkbox"/> Hoisting Requirements	<input type="checkbox"/> Therapy (physio, OT etc) <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Learning Disability <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Other - Please state below

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MEDICAL		
Please list all the medical professionals involved with your child's care.       Other – please specify e.g. specialist nurses	Consultant	
	Consultant	
	Physiotherapist	
	SALT	
	OT	
	NHS Community Nurse	
COMMUNICATION		
How does the child you care for express themselves and communicate? E.g. Makaton, BSL.		
Does the child you care for use a communication aid? If yes, what is it eg PECS.		
Does the child you care for have social communication issues? If yes, please describe.		
Does the child you care for have physical communication issues? If yes, please describe.		
Does the child you care for have difficulties in managing their feelings and emotions? If yes, please describe.		
BEHAVIOUR		
Does the child you care for have any challenging behaviour which is likely to cause a problem while taking part in activities with other children? If yes, can you describe what those behaviours are and how they are managed?		
SENSORY PERCEPTION		
Does the child you care for have any sensory differences or difficulties? Please describe what they are and how they affect your child e.g. coping with light or noise etc		
Please tell us how the child you care for can be assisted to cope with their sensory problems.		

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EDUCATION	
What playgroup, nursery, primary or secondary school does your child attend?	
Named teachers involved with your child's care	
SOCIAL WORK	
Does your child have a named Social Worker? Please provide details.	
OTHER AGENCIES	
Does your child have interaction or support from other agencies or organisations e.g. Befriend a Child, Home Start, CHAS? Can you provide details.	
ADDITIONAL INFORMATION	
<p>This section is to let us know if there is anything else about your child that you feel is important to tell us.</p> <p>You can also tell us about your child's sibling(s). We have specific referral forms for siblings requiring support</p>	

CHILD SUPPORT NEEDS: TICK AS APPROPRIATE:	WHAT DO YOU HOPE TO ACHIEVE AS A FAMILY?
<b>ACTIVITIES</b> <input type="checkbox"/> Family Group activities <input type="checkbox"/> Short Stay Breaks <input type="checkbox"/> Under 5s Group Activities <input type="checkbox"/> Parent Carer Activities <input type="checkbox"/> Sibling Activities <input type="checkbox"/> Holiday Activities <b>SUPPORT</b> <input type="checkbox"/> Advocacy <input type="checkbox"/> Managing Feelings and emotions <input type="checkbox"/> Information & Guidance <input type="checkbox"/> 1:1 support <input type="checkbox"/> Family Support <input type="checkbox"/> Sibling Support <input type="checkbox"/> Support parents/carers having difficult conversations with children <input type="checkbox"/> Keeping memories safe <input type="checkbox"/> Pre/ Post Bereavement support <input type="checkbox"/> Observations <input type="checkbox"/> Support with Multi-agency meetings	<input type="checkbox"/> Meeting other families <input type="checkbox"/> Increase Confidence <input type="checkbox"/> Support to talk to children about difficult situations <input type="checkbox"/> Work on strategies and techniques to manage feelings and emotions <input type="checkbox"/> Help improve concentration <input type="checkbox"/> Support to attend family activities <input type="checkbox"/> More family themed activities <input type="checkbox"/> Increased family time <input type="checkbox"/> Pre-bereavement support <input type="checkbox"/> Post bereavement support <input type="checkbox"/> Signposting to other organisations <input type="checkbox"/> Other please state

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HOW DID YOU HEAR ABOUT CHARLIE HOUSE?	ONCE COMPLETED, PLEASE RETURN FORM TO:
<input type="checkbox"/> Friend/Family <input type="checkbox"/> Social Media <input type="checkbox"/> Health Care Professional <input type="checkbox"/> Educational Professional <input type="checkbox"/> Social Work <input type="checkbox"/> TV or Radio campaigns <input type="checkbox"/> Newspaper or magazine publications <input type="checkbox"/> Website If other, please state:	<p>Leigh Ryrie Children &amp; Family Support Manager Charlie House Balmoral House, 74 Carden Place ABERDEEN AB10 1UL leigh@charliehouse.org.uk</p>

I \_\_\_\_\_ confirm that I am the Parent/Carer for \_\_\_\_\_

By signing, I understand the reasons for the referral, the referral forms have been clearly explained to me and I am giving consent for this referral to be processed.

Charlie House recognises the value of your Personal Data and, as such, treat this with a high degree of care and security. By signing below, you give Charlie House consent to process your Personal Data in line with our Members Privacy Notice.

SIGNATURE	
DATE	