**Health Wellbeing and Care Hub**

**Children’s Services Referral Form**

Please give as much information as possible. This will help us to process your referral quickly and appropriately. If you require support to complete the form, please contact us on 01206 872460 or email [healthwellbeingcare@essex.ac.uk](mailto:healthwellbeingcare@essex.ac.uk). Please attach any additional information on a separate sheet.

Your care will be provided by our student workforce under the supervision of HCPC registered practitioners. Please tick the box to give consent to be seen by our students

Services available: please highlight or tick the service/s you are referring to:

**Wiggle and Words** – a language enrichment and movement group for preschool children with Down Syndrome.

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| **Child’s Details** | | | | | | | | | |
| Forename: | | | | | | Surname: | | | |
| Date of Birth: | | | | | | Gender: | | | |
| Address:  Postcode: | | | | | | | | | |
| Ethnicity: | | | | | | First language: | | | |
| Preschool/School Name and Address: | | | | | | Name of preschool lead/teacher | | | |
| **Disabilities (please indicate relevance to this referral)** | | | | | | | | | |
| Learning Disability |  | Physical Impairment |  | | | Sensory Impairment |  | Other |  |
| Additional Information: *(Please include developmental milestones where appropriate; strengths and needs)* | | | | | | | | | |
| **Medical History** | | | | | | | | | |
| Ear Infections | | | | | Tonsillitis | | | | |
| Hospitalisations / Major Illnesses: | | | | | Other Medical Conditions and Medications: | | | | |
| **GP Details** | | | | | | | | | |
| Registered GP: | | | | Telephone: | | | | | |
| GP Practice Address: | | | | | | | | | |

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| **Family Information** | |
| Names of Parents / Carers: | Address and postcode (if different from above): |
| Home Telephone: | Mobile Telephone: |
| Email: | |
| Preferred contact method:  Phone  Email  Letter | |

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| **Speech, Language and Communication Skills** – Please  as appropriate | | | | | |
| Poor Attention / Listening | |  | Difficulty Following Instructions | |  |
| Difficulty Linking Words | |  | Limited Vocabulary | |  |
| Unclear Speech Sounds | |  | No Useful Speech | |  |
| Stammer | |  | Unintelligible to Family / Outside Family | |  |
| **Please indicate age of:** | | | | | |
| Babble | First Real Words | | | Simple Phrases | |

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| **Referrer Details** | | | |
| Referrer Details:  (if not parent/carer)  Name and organisation. |  | Date of referral: | Click or tap to enter a date. |
| Referrer’s Address: |  | Email: |  |
| Telephone Number: |  | Consent obtained to send: | Yes  No |

**Please email the completed form to: healthwellbeingcare@essex.ac.uk**

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| **Office use only:**  Indicated input required: | | | |
| Physiotherapy |  | Speech and Language Therapy |  |
| Occupational Therapy |  |  |  |
| Comments: | | | |