**Referral to School-Age Neurodevelopmental Pathway – Central and West Lancashire**

**General points**

The School-Age ND Pathway is for children and young people (CYP) between the ages of 5 (5th Birthday) to either 16 years of age or December 31st of Year 11 (equivalent if home schooled) whichever comes first. For younger children please refer to the local child development centre. For older children your GP can refer to the commissioned provider.

This referral process covers CYP who have a GP within Central and West Lancashire and not parental address or school location.

* Parental information is mandatory and should be provided directly by the parent although support can be provided if required.
* Professional sections must be completed by the professionals holding this evidence and performing their own assessments that led to the referral (*please note for school age children school evidence is strongly encouraged*).
* Electronic completion is mandatory and submission to the email address, if parents wish to write their parts, please feel free to transfer directly to the form.
* Consent must be completed by the family, and we encourage you to go through each of the items they are agreeing to, therefore ensuring this is fully informed consent.
* Please ensure the professional referrers email address is included, as the response to referral will be sent via secure email to comply with GDPR.

The form should then be scanned and emailed to the ND Pathway team at the following email address: [bfwh.centrallancs.ndp@nhs.net](mailto:bfwh.centrallancs.ndp@nhs.net)

When submitting a referral form, if you have not receive a triage outcome letter within 4 weeks please contact the ND team to following this up via the above email address.

**PLEASE NOTE: As the triage service is being delivered by Blackpool Teaching Hospitals NHS Foundation Trust, we do not have access to any local or hospital medical records therefore please summarise any important information relevant to this referral.**

**Referral to School-Age Neurodevelopmental Pathway**

***N.B: Please ensure that you complete each section of this form. Comprehensive information at this stage will assist us to direct this referral appropriately. The referral may be returned to you if there is insufficient information.***

**Information about the child or young person you are referring, all boxes within this section must be completed.**

|  |  |
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| **Name:** |  |
| **Address:** |  |
| **Date of birth:** |  |
| **Male / Female:** | Male Female |
| **NHS Number:** |  |

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| **GP name:** |  |
| **GP address:** |  |
| **GP telephone number:** |  |

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| --- | --- | --- | --- |
| **Parent/Carer Name** |  | **Parent/Carer Name** |  |
| **Relationship** |  | **Relationship** |  |
| **Address (if different from above)** |  | **Address (if different from above)** |  |
| **Parent/Carer Telephone Numbers** | Home Tel no: | | |
| Mobile tel. no (mother): | | |
| Mobile tel. no (father): | | |
| **Who has parental responsibility for the child/young person?** |  | | |
| **Does the Child/young person have an EHCP in place?** | Yes No | | |
| **Is the Child/young person undergoing an Education, Health and Care Needs Assessment?** | Yes No | | |
| **Does your child need any additional consideration when attending for appointments?**  **If so, please include details of these.** | Yes No | | |
| **Is the child or young person a Looked After Child or the subject of any special Orders e.g.** **Special Guardianship Order, Child Arrangements Order, Residence Order** | Yes No | | |
| **If Yes please give details including name of person with parental responsibility** |  | | |
| **Is the child or young person adopted** | Yes No | | |
| **If Yes please give details** |  | | |
| **School Information** | | | |
| **School:** |  | | |
| **School address:** |  | | |
| **School tel. number:** |  | | |
| **School year group:** |  | | |
| **School e-mail address** |  | | |

**Information about referral agent (*Mandatory-this must be a professional who is lead for completing this form*)**

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| **Name:** |  |
| **Designation:** |  |
| **Location:** |  |
| **Contact address** |  |
| **Contact telephone number:** |  |
| **Contact email address:** |  |
| **Date of referral:** |  |

**Profile of child/young person (professional perspective)**

Please summarise your main concerns about the child or young person that you are referring to the ND Pathway. There will be the opportunity to give more detail in further sections of the form; this section enables you to give a “pen portrait” overview of the child or young person. Consider the following when completing this section:

* What are your main concerns about the child or young person?
* What makes them different from a typical child or young person of the same age?
* What do different professionals think? (if co-produced by different agencies)

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| **What are your main concerns that make you think autism is a potential diagnosis in this child/young person?** |
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**Parental concerns**

Parent/carer concerns should be given from the perspective of the parents/carers and gained from your discussions with them. If you are giving any information that is not gained from parents/carers themselves, this must be explicitly stated, and the source identified.

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| **Parental concerns**  **As a parent, do you believe your child has autism? (and if so, please describe why you believe that is the case)** | | |
|  | | |
| **Are there differences that are currently not being fully supported/needs not met? If so, please explain what these are, and why they are not being supported and what your current plans to resolve these issues are (this can include parental challenges, as well as any professional group such as, school, mental health, social care)** | | |
|  | | |
| **If there are differences that have been solved, please describe what has been done, when this was instigated and any plans for the future (please give details of any professionals involved below)** | | |
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| **Other Investigation (please describe any pathways, referrals or investigations, by other professionals that are currently being completed) and who these are being completed by.** | | |
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| **PLEASE NOTE: As we are not in central Lancashire, we don’t have access to any local or hospital medical records therefore please summarise any important information.** | | |

**What do you consider to be the child’s/young person’s strengths? What can they do well?**

Please give as many strengths as possible, considering all aspects of the child e.g. learning, behaviour, personality etc.

It is important that the ND Pathway team build a full and rounded picture of the child or young person.

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| **What do you consider to be the child’s/young person’s strengths? What can they do well?** |
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**Information re: any current health or medical issues**

Please complete this section as fully as possible, giving details of medications etc. where possible.

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| **Information re: any current health or medical issues:** |
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**Information regarding family (history, circumstances etc.)**

Please include information about

* siblings, others living in the home
* any relevant information about the family
* family history of neurodevelopmental or other conditions
* any information about family circumstances or relationships relevant to this referral

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| **Information regarding family (history, circumstances etc.)** |
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**Are there any safeguarding issues relating to this child, young person or family? If yes, please give details.**

e.g. domestic violence, Child in Need, strategy meetings, CAF/TAF etc.

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| **Are there any safeguarding issues relating to this child, young person or family? If yes, please give details.** |
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**Are there any active mental health issues, including risks to self or others (if yes please confirm that these are being addressed through alternative routes, as this is not covered by the ND Diagnostic Pathway)**

This should include information about risks to the child or young person (e.g. self-harm, mental health issues).

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| **Are there any risk factors relating to this child, young person or family? If yes, please give details.** |
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**Information re: child’s/young person’s educational attainment *(this section is mandatory and unless a child is home schooled, must be completed by the school SENCo)***

Please complete this section as fully as possible giving test scores, current/expected levels where appropriate. Information about a child or young person’s learning style, learning ability and attainment is essential when building a full profile of that child or young person.

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| **Information re: child/young person’s educational attainment** |
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**Child’s/young person’s voice (***if applicable***)**

Child’s/young person’s voice should be given from the perspective of the child or young person themselves; they should be gained from your direct experiences/discussions with them.

If you are giving any information that is not gained directly from the child or young person, this must be explicitly stated and the source identified.

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| **Child’s/young person’s concerns**  **Do you have any worries about the way you think, feel, behave etc.? If so, what are your worries?** |
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| **Do you think you have autism?** (if yes why do you think this) |
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| **Do you think you have any other differences?** (if so what do you think these could be) |
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| **Clarification before consent: Could both the professional referrer and the family confirm they are seeking a diagnostic pathway for autism** | |
| **Referrer:**   * Please confirm explicitly that there is no treatment, support, educational help, statutory assessment, or EHCP, mental wellbeing, mental health, sensory, behaviour, or any other problems that require help that are currently not being escalated separately to this pathway. * Within your area the presence or absence of autism has no impact in accessing the needs-based support for the problems above and this is not a reason for referral to this pathway.   Please confirm that you understand and agree to this: | **Family:**   * Please confirm explicitly that there is no treatment, support, educational help, statutory assessment, or EHCP, mental wellbeing, mental health, sensory, behaviour, or any other problems that require help that are currently not being escalated separately to this pathway. * Within your area the presence or absence of autism has no impact in accessing the needs-based support for the problems above and this is not a reason for referral to this pathway.   Please confirm that you understand and agree to this: |

Please ensure the person with parental responsibility for the child or young person

* is shown the contents of the completed referral form
* agrees with the content of the completed form
* understands that the referral is being sent to the ND Pathway team
* understands the role and function of the ND Pathway team (aims as above)
* understands that information about the child or young person may be requested from other agencies by the ND Pathway team and will be shared with the team.
* If consent is given but for limited, specific agencies only, these need to be clearly recorded.

The parent should then complete the bottom section of the form to indicate their awareness of all the points above.

Referrals will not be accepted if parental consent is not obtained and evidenced as above.

**Please ensure that the contents of this referral form have been discussed fully with parent/person with parental responsibility and that this final page of the referral form has been completed before the referral is submitted.**

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| **CONSENT**  **I am signing this form to confirm that:** | | |
| **I have parental responsibility for ……………………………………………………….** | | |
| **I have seen the fully completed version of this form.** | **Yes** | **No** |
| **I have filled in my own sections and not the professional sections** | **Yes** | **No** |
| **I agree with the contents of the form** | **Yes** | **No** |
| **I give my consent for a referral to be made to the School-Age (ND) Neurodevelopmental Pathway** | **Yes** | **No** |
| **I give consent for relevant information about the above named child to be request by / share with members of the School-Age ND Pathway Team** | **Yes** | **No** |
| **I give my consent for relevant information about the above-named child to be requested from CAMHS and shared with members of the School Age Neurodevelopmental Pathway team** | **Yes** | **No** |
| **I give my consent for referrals to be made for other professional assessments as deemed appropriate for progression through the neurodevelopmental pathway.** | **Yes** | **No** |
| **I understand that in my area currently there is no service to provide the assessment for autism if indicated for my child (when this is available you will be contacted)** | **Yes** | **No** |
| **I give consent to Blackpool Teaching Hospitals to perform a clinical triage and assessment of the referral to ensure this referral is appropriate based on the evidence provided within the referral** | **Yes** | **No** |

**Signature: …………………………………………………………………………………………………**

**Name: ……………………………………………………………………………………………………….**

**Relationship to child: ………………………………………………………………………………….**

**Date: …………………………………………………………………………………………………………..**

**\*\*Please note this referral will not be accepted unless the above section is fully completed\*\***

**Please email the completed form to:** [bfwh.centrallancs.ndp@nhs.net](mailto:bfwh.centrallancs.ndp@nhs.net)

**If you have not received a triage outcome letter within 4 weeks of submitting the referral, please get in touch with the team via the above email address.**

**If you have any questions, please feel free to contact the team via email.**