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Children and Young People’s Services Referral Form

**\* Starred fields are mandatory. If any of these fields are not completed the form will be returned.**

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| **Paediatric Bladder and Bowel Service**  **01925 946732**  **bchft.paediatricbladderandbowel@nhs.net** | **Other –** please state |  |

|  |  |
| --- | --- |
| **Surname:\***  **Forename:\***  **Previous Surname:**  **Address:\***    **Is copy appointment letter required:** Yes / No  **Please give details:** | **Date of Birth**:**\***  **NHS Number:\***  **Gender:\***  **Home Telephone:\***  **Mobile Telephone:**  **E-mail Address:**  **Reminder required for appointments (if available):**  **Text:** Yes/No |

|  |  |
| --- | --- |
| **Religion:\***  **Ethnicity:\***  **Access/Communication Needs:** | **\*Language Spoken:**  **\*Interpreter Required:**    **Preference for interpreter: Male Female**  (Please delete as appropriate ) |

|  |  |
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| **Early Help Assessment (EHA) Completed:** yes/no **\***  **Lead Professional:**  **Name:**  **Address:**  **Telephone:**  **Other Professionals Involved:** | **GP Name:**  **Practice Name:**  **Practice Address:**  **Nursery / School Attended:** |

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| **\*Diagnosis:**  **\*Reason for referral:** | **\*Additional information (please provide evidence of advice/treatment already given e.g ERIC):**  \***EHCP/SEND in place:** |

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| **\*Referrer Name:**  **Designation:**  **Address:**  **Telephone:** | **Date of referral:**    **\*Have parents agreed to referral?** |