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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 |  |

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| --- | --- |
| **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  |

|  |  |
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| **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?**   |