People at our heart

NHS
Coventry and Warwickshire Partnership
NHS Trust

Children's Physical Health Single Point of Access

Complex Physical Health MDT Referral Form

Previously New to Country/City

This referral form is for Children or Young people with complex physical health needs who are new to requiring MDT (Multidisciplinary Team) input from multiple physical health services. This includes children and young people who are new to country/city.
On acceptance of this referral, the child or young person will be triaged to determine which services are required in which priority.

Please select one of the below

New to Country/City	☐	New to requiring MDT input	☐

Child or young person being referred

Surname of Child/Young Person				
First Name(s)				
Date of Birth		Age of Child		
NHS Number				
Gender (please tick)	Male	☐	Female	☐
Address				
Postcode				

Ethnicity Category (please tick)

☐ White British	☐ Mixed White and Black African	☐ Asian/Asian British Pakistani	☐ Black/Black British other	☐ Other Ethnic Group
☐ White Irish	☐ Mixed White and Black Asian	☐ Asian/Asian British Bangladeshi	☐ Eastern European	☐ Not known
☐ White/Other White Background	☐ Mixed Other Background	☐ Asian/Asian British Caribbean	☐ Black/Black British African	☐ Not stated
☐ Mixed White and Black Caribbean	☐ Asian/Asian British Indian	☐ Other Ethnic Groups Chinese	☐ Eastern European	

Details of Parent/Carer

Parent Carer's Name(s)	
Relationship to child/young person	
Address *(if different from above)*	
Email address *(consent to receive emails if given)*	

Telephone contact number		Consent to SMS text reminder	Yes ☐ No ☐
Home Language CWPT values multilingualism and views this as an advantage. The Trust encourages families to communicate with their children in the way which feels most natural which will include using languages used in the home environment.	Is an Interpreter required?	Yes ☐ No ☐	
	If yes, please state which language:		

Referral Information

IMPORTANT: Referral Information required

Please indicate by ticking the below boxes the services the Child or Young Person **may** require. (Must be two or more)

If the Child/Young Person requires only one service referral, please follow the existing referral route.

Community Paediatrics ☐	Children's Physiotherapy ☐	Children's Respiratory Physiotherapy ☐
Children's Occupational Therapy ☐	Children's Dysphagia ☐	Children's Bladder & Bowel ☐
Children's Community Nursing ☐	Children's Dietetics ☐	Wheelchair Services ☐
Please detail diagnosis and health needs		
Please detail current medications including dose		

Is this Child/Young Person known/being seen by other services – please tick to indicate which	Are known to Social Care	☐	Child Protection Plan	☐
	In the care of the Local Authority	☐	(if yes above) Do they have a Social Worker	☐

Referrer Details

Referred by Full Name	
Referrers email address	
Referrers address	
Postcode	
Referrers telephone number	
Designation or relationship to Child or Young Person	
Referrer Signature *(electronic is acceptable)*	
Referral Date	

Please tick to indicate you have attached medical letters, reports, scans, and information regarding any referrals made to other services ☐

GP Details (Coventry only CV1 – CV6)

Section must be complete for referral to proceed

GP Name			
GP Practice address			
Postcode		GP telephone number	
If child or young person is not registered with a GP please detail actions taken to support registration			

Please return referral and attach any other relevant medical information [scans, clinic letters, reports etc] by email to Referrals.ChildrensPhysicalHealth@covwarkpt.nhs.uk

Or by post to: Children's Physical Health Referrals, Wayside House, Wilsons Lane, Coventry CV6 6NY