

**Single Point of Entry (SPE) referral form**

**Children & Young People’s Services**

Bristol, North Somerset & South Gloucestershire

When completed please return to: sirch.singlepointofentry@nhs.net or Single Point of Entry, Eastgate House, Unit 9, Eastgate Office Centre, Eastgate Road, Eastville, Bristol, BS5 6XX

**Please note:** Completion of all fields is mandatory. Incomplete or incorrect forms (including incorrect versions) will be returned, which will delay the referral process. **Before completing or submitting the referral please check eligibility and referral criteria for each service.**

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| --- | --- | --- | --- |
| Child/Young Person’s Surname: | Forename/s: | Date of Birth: | Gender:  |
| NHS No: | Ethnicity: |
| Home address:Postcode: Home telephone number:Mobile number:Email address: | Name of main carer:Relationship to Child:Who has parental responsibility? (please list)Name and address (if different from the child or young person)1.2.Has a person with parental responsibility agreed to this referral:Yes [ ]  No [ ]  |
| School/Nursery/Preschool name and address: | Child/Young Person’s GP Name and Address:Has GP been informed? Yes [ ]  No [ ]   |
| Child’s first language ……………………………………….. Parents’ first language ………………………………………Is an interpreter or signer required? Yes/No (please indicate) If yes the service required…………………………………...Can parents/carers access written information? Yes/No (please indicate) | Is this child/young person a Child Looked After?Yes [ ]  No [ ]  Unknown [ ]  |
| Is this child/young person subject to a Child Protection Plan? Yes [ ]  No [ ]  Unknown [ ]   |
| To ensure we communicate effectively and efficiently with our parents/carers/ young people, we often use digital methods of communication for appointment booking & reminders, appointment letters, requisition of questionnaires or other documents, signposting to relevant resources, requests to contact the service where action is required and for friends & family feedback surveys. Does the person with parental responsibility give consent for us to contact them for the above purposes by:(Our primary, agreed method is by post and phone call). Text Yes [ ]  No [ ] Email Yes [ ]  No [ ]  **For further information on how the organisation collect, use, retain and disclose personal information please refer to our privacy notice on our website** [**www.sirona-cic.org.uk**](http://www.sirona-cic.org.uk) |
| **Referred by:** (Please note - The fields below MUST be completed to enable us to process the referral)I confirm that a person with parental responsibility has given their consent for this referral and for appropriate services to be allocated. Referred by (name): …………………………………… Date: ……………………………………………Role: ……………………………………………Address: ……………………………………………………………………………………………………….Telephone number (s): ………………………………… Email address: ………………………..............  |
| **Reason for referral:** (NB - If preferred, please attach a report with **clear** indication of the reasons for referral)Please explain the impact of this problem on the child/young person’s daily life:Please outline any strategies that have been used to help the child/young person and whether these have been successful:**(Continue on separate sheet if necessary)** |
| Relevant History Including key areas of concern**(e.g. Medical, developmental issues, family structure)*****Please attach any relevant reports including CAF assessment.*** |
| Which other professionals are already involved with this child/young person?

|  |  |  |
| --- | --- | --- |
| **Name** | **Service** | **Address** |

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| **Referral to:** *Please indicate the profession(s) you would like the child/young person to be assessed by.*NB: Clinical staff will consider whether the child will need to be seen by one service, a combination of services or a more appropriate service than the one referred to. The decision will be based on the information you provide. The outcome will be included in your acknowledgement letter. |
| **Please note: required additional information forms*** \*if you are referring to the ASD diagnostic assessment please ensure the essential referral documents found on our website are included [making a referral – children and young people’s services (sirona-cic.org.uk)](https://sirona-cic.org.uk/children-services/resources/making-a-referral/)
* \* if you are referring to the Continence Service please ensure the essential referral document Continence\_SPE\_Attachment found on our website is included [Children’s Continence Services – Children and Young People’s Services (sirona-cic.org.uk)](https://sirona-cic.org.uk/children-services/services/childrens-continence-services/)
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| 1. Child & Adolescent Mental Health Service/Learning Disabilities\* (CAMHS/LD)

(See Referral Criteria for definitions of Learning Disability) |  | 5. Speech & Language Therapy |  |
| 6. Physiotherapy |  |
| 1. Community Paediatrics
 |  | 7. Occupational Therapy |  |
| 1. ASD Diagnostic Assessment Service \*

Early Years [ ] School Age [ ]  |  | 8. Early Support Practitioners (Bristol Only) |  |
| 1. Continence Service \*
 |  | 9. Specialist Children’s Learning Disability Service |  |