

**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](mailto: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.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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** | | | | | | | | |
| **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/) | | | | | | | |
| 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. Children’s Bladder & Bowel | |  | 9. Specialist Children’s Learning Disability Service | | | |  |