

**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.**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Nature of Referral: Urgent  Routine | | | | | | | |
| Child/Young Person’s Surname: | Forename/s: | | | Date of Birth: | | | |
| NHS No: | | | | Gender: | | | |
| Ethnic Category – please choose one option that best describes the child/young person’s ethnic group or background: | | | | | | | |
| White:  English/Welsh/Scottish/Northern Irish/ British  Irish  Gypsy or Irish Traveller  Roma  Any other white background, please describe……… | | | | Black/African/Caribbean/Black British:  African  Caribbean  Any other Black/African/Caribbean background, please describe……….. | | | |
| Asian/Asian British:  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background, please describe…….. | | | | Mixed/Multiple Ethnic Groups:  White and Black Caribbean  White and Black African  White and Asian  Any other Mixed/Multiple ethnic background, please describe…….. | | | |
| Other Ethnic group:  Arab  Any other Ethnic group, please describe…….. | | | | Not stated | | | |
|  | | | | | | | |
| 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)  Information Sharing:  Does the person with legal responsibility consent to information sharing? (See website for further details)  Yes  No  It is important to ensure that the parent/carer is aware that the information detailed in referrals made to Community Paediatric Services may be shared with other health professionals and external agencies who are closely associated with health professionals, such as education or social services. More information is available at [www.connectingcarebnssg.co.uk](http://www.connectingcarebnssg.co.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. AWP    1. Child & Adolescent Mental Health Service (CAMHS)    2. Learning Disabilities  (See Referral Criteria for definitions of Learning Disability) | |  | 5. Speech & Language Therapy (If referring for commissioned services or via a drop-in please select below, otherwise use the box to the right)  Commissioned  Drop-in (Therapists only) | | |  |
| 6. Physiotherapy (If referring for commissioned services or via a drop-in please select below, otherwise use the box to the right)  Commissioned  Drop-in (Therapists only) | | |  |
| 1. Community Paediatrics (if referring for an ADHD assessment please select below, otherwise use the box to the right)   ADHD referral | |  | 7. Occupational Therapy (If referring for commissioned services or via a drop-in please select below, otherwise use the box to the right)  Commissioned  Drop-in (Therapists only) | | |  |
| 1. ASD Diagnostic Assessment Service \*   Early Years  School Age | |  | 8. Early Support Practitioners (Bristol Only) | | |  |
| 1. Children’s Bladder and Bowel Service | |  |  | | | |