South West London and St George's NHS
Mental Health NHS Trust
Specialist Services

Deaf Child, Young People & Family Service
Building 8, "Cornerhouse"
Springfield Hospital
61 Glenburnie Road
London
SW17 7DJ

tel: 020 8682 6860/6802
fax: 020 8682 6909
minicom: 020 8682 6689
cornerhouse@swlstg-tr.nhs.uk

South West London & St. George's Mental Health NHS Trust also provides an outpatient service for Deaf children with mental health problems

Inpatient Referral Form

- Please complete this form in as much detail as possible, as it will enable us to appropriately prioritise your referral
- When completed, please return this form to the contact details above

N.B. Consent must be obtained from the parent/carer before referral

☐ **Please tick box to confirm consent has been obtained from parent/carer**

Referral Information				Date of Referral:
Referrer Name:				Relationship to client: (If you are a professional working with this person please state your job title)
Referrer Address:	Contact details: (please tick preferred)			
	☐ Minicom:		☐ Mobile/ SMS:	
	☐ Voice phone:		☐ Fax:	
Post code:	☐ Email address:			

Client Details				
Name:				Date of birth: Gender: ☐ Male ☐ Female
Address:	Contact details: (please tick preferred)			
	☐ Minicom:		☐ Mobile/ SMS:	
	☐ Voice phone:		☐ Fax:	
	☐ Email address:			
Post code:	☐ Other:			

Communication: (please tick)
- ☐ Speech
- ☐ SSE
- ☐ Makaton
- ☐ BSL

Ethnicity: (please tick)
- ☐ Asian
- ☐ Asian-British
- ☐ Black-African
- ☐ Black-British
- ☐ Black-Caribbean
- ☐ Black Other
- ☐ Chinese
- ☐ White British
- ☐ White Other
- ☐ Other: (please specify)
- ☐ Prefer not to answer

NHS Number:

Religion (please describe):

Nationality:

Other key people involved supporting the client

GP (home)			
GP Name:	GP Contact details:		
GP Address:	Telephone:		
	Fax:		
	Primary Care Trust:		

GP (school)					
GP Name:	GP Contact details:				
GP Address:	Telephone:		Mobile/ SMS:		
	Fax:		Fax:		
	Email address:				
	Other:				

Social Worker					
Name:	Contact details:				
Address:	Minicom:		Mobile/ SMS:		
	Voice phone:		Fax:		
	Email address:				
	Other:				

Speech & Language Therapist					
Name:	Contact details:				
Address:	Minicom:		Mobile/ SMS:		
	Voice phone:		Fax:		
	Email address:				
	Other:				

N.B. Please give full details of local CAMHS for the child, even if they are not seeing them.

CAMHS					
Name:	Contact details:				
Address:	Minicom:		Mobile/ SMS:		
	Voice phone:		Fax:		
	Email address:				
	Other:				
☐ Currently seeing	☐ Previously seen		☐ Never seen		

School					
Name:	Contact details:				
Address:	Minicom:		Mobile/ SMS:		
	Voice phone:		Fax:		
	Email address:				
	Other:				
Headteacher:					
School Type:			Date started:		
Residential: ☐ Yes	☐ No	☐ Sometimes	Date started residential:		

Main Reason for Referral (Please give a short description of why this person has been referred)

Any Recent Changes
(e.g. new teacher / class / residence)

Problems at home
(give dates and detailed description)

Problems at school
(give dates and detailed description)

Social Services involvement
(e.g. subject to a Child Protection Plan, care proceedings)

Family Information
(people currently living at home)

	Name	Age	Relationship	Deaf / hearing / HoH	Can they sign BSL?	Can they sign another language?	Main language spoken
EXAMPLE	*Mr Piotr Smith*	*31*	*Father*	*Hearing*	*Yes – basic*	*No*	*Polish*
	Mrs Pam Smith	*33*	*Mother*	*Deaf*	*Yes*	*Yes – ASL*	*English - basic*

Family Information continued		
Is a foreign language interpreter needed to communicate with the family?	☐ Yes	☐ No
Family's preferred method of communication: (please give contact numbers / addresses)	☐ Phone: ☐ Text (SMS): ☐ Minicom: ☐ TypeTalk: ☐ Email:	

Medical History	
Cause of deafness:	Date diagnosed:
Current medical condition(s):	
Other additional needs:	

When parental consent has been received, please send copies of relevant assessments and reports (e.g. medical, psychological, social services, speech and language therapy). Both historical and current information should be included.

N.B. Delays in sending relevant reports will cause delays in processing this referral

Signature: _____ Date: _____

Name: _____

Thank you for taking the time to complete this form