

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.

Urgency 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(s) with parental responsibility agreed to this referral: Yes ☐ No ☐

Service provided by



School/Nursery/Preschool name and address: If the child or young person is not in education or is homeschooled, please indicate: Not in education ☐ Homeschooled ☐	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 (text and/or email) where appropriate, for appointment booking & reminders and requests to contact the service where action is required. You can opt-out of these methods at any time by contacting the relevant service. 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 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/young person 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 involved in providing direct care to the child/young person to ensure they have accurate, up-to-date and relevant information to enable them to provide safe and effective care. More information is available at www.connectingcarebnssg.co.uk, EMIS Record Sharing and Policies - Sirona care & health.	
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 service please ensure the essential referral documents found on our website are included [making a referral – children and young people's services \(sirona-cic.org.uk\)](http://sirona-cic.org.uk/making-a-referral-children-and-young-peoples-services)
- *if you are referring to Community Paediatrics for an ADHD assessment please ensure the essential referral documents found on our website are included [Attention Deficit Hyperactivity Disorder \(ADHD\) referrals – Children and Young People's Services \(sirona-cic.org.uk\)](http://sirona-cic.org.uk/attention-deficit-hyperactivity-disorder-adhd-referrals-children-and-young-peoples-services)
- *if you are referring to Community Paediatrics for ongoing care following an ADHD diagnosis made by a private provider or another NHS Service, please include the diagnosis report.

☐ **Community Paediatrics**

Is the referral for an ADHD assessment?

Yes ☐ No ☐

Is the referral for continuation/consideration of ADHD medication?

Yes ☐ No ☐

☐ **ASD Diagnostic Service**

Early Years ☐

School Age ☐

☐ **Speech & Language Therapy**

Is the referral for an eating and drinking problem?

Yes ☐ No ☐

Is the referral for Education Commissioned Services?

Yes ☐ No ☐

Is the referral following a drop-in (Therapist only)?

Yes ☐ No ☐

☐ **Physiotherapy**

Is the referral for Education Commissioned Services?

Yes ☐ No ☐

Is the referral following a drop-in (Therapist only)?

Yes ☐ No ☐

☐ **Occupational Therapy**

Is the referral for Education Commissioned Services?

Yes ☐ No ☐

Is the referral following a drop-in (Therapist only)?

Yes ☐ No ☐

☐ **Children's Bladder and Bowel Service**

☐ **Early Year's Support Practitioners (Bristol Only)**

☐ **Community Eye Clinic (Internal Referrals from Community Paediatrics only)**