**SINGLE POINT OF REFERRAL (SPOR) FORM:  
CAMDEN COMMUNITY CHILDREN’S SERVICES**

**Please use this form to refer to:**

* **Occupational Therapy**
* **Paediatrics**
* **Physiotherapy**
* **Speech and Language Therapy**
* **MOSAIC – Integrated Service for Disabled Children**
* **Dietetics**

**Send completed forms to:** [**adminspor.cnwl@nhs.net**](mailto:adminspor.cnwl@nhs.net). **Please, do not post this form.**

**If the child’s only concern is related to mental health, please send a referral letter to Joint Intake Services, Tavistock Clinic, 120 Belsize Lane, London, NW3 5BA, or call them on 020-8938-2638.**

**How to use this form**

1. **Sections 1, 2 and 4 must be completed. Please ensure you have obtained consent for this referral – documented in Section 1.**
2. You can use this form to refer to one or more services at the same time. **Please tick the child’s main areas of need in Section 4**. This information will be used to make sure the referral gets to the right team quickly.

1. **Complete all other relevant sections to the child’s needs. You do not need to complete every subsequent section**. Please only go to the areas of need you have highlighted in Section 4 and provide detail about why you are referring. This detail helps us ensure children receive the right treatment or intervention as quickly as possible.
2. **Please attach any relevant documentation (e.g. reports, letters).**
3. **Items marked with an asterisk must be completed**.

**Section 1:**

**Please only complete one section – parent/carer or professional**

***For a parent / carer who is completing the form***

**I understand the information that is recorded on this form. I understand that this information will be stored and used for the purpose of providing health services to:**

This infant, child or young person for whom I am a parent / carer

**Referrals made via the Single Point of Referral (SPOR) may be discussed at a multidisciplinary panel in order to achieve the best outcome for the child and we will let you know the outcome. This may lead to a different pathway for the child to the one that you have requested. I have had the reasons for information sharing explained to me and I understand those reasons.**

**I agree to the sharing of information with professionals within children’s services for the purposes of referral. I understand this may include gathering information from healthcare professionals my child is currently known to and /or those my child was previously known to. This may include the following health services; Health Visiting, Paediatrics, Occupational Therapy, Physiotherapy, Speech and Language Therapy.**

Yes  No

**You have the right to access your personal and health records. Please speak to the health care professional working with your child, or their line manager for further details.**

***For a professional who is completing the form***

**I have discussed the information that is recorded on this form with the child’s parent / carer. The parent / carer has stated that they understand that it will be stored and used for the purpose of providing health services to:**

This infant, child or young person for whom they are a parent / carer

**Referrals made via the Single Point of Referral (SPOR) may be discussed at a multidisciplinary panel in order to achieve the best outcome for the child and we will let you know the outcome. This may lead to a different pathway for the child to the one that you have requested. I have explained the reasons for information sharing to the child’s parent / carer and they have stated that they understand those reasons.**

**The child’s parent / carer agrees to the sharing of information with professionals within children’s services for the purposes of referral. The child’s parent / carer understands this may include gathering information from healthcare professionals their child is currently known to and / or those their child was previously known to.**

**This may include the following health services; Health Visiting, Paediatrics, Occupational Therapy, Physiotherapy, Speech and Language Therapy.**

Yes  No

**You have the right to access your personal and health records. Please speak to the health care professional working with your child, or their line manager for further details.**

**Please detail if any information should not be shared with particular agencies:**

**Section 2:**

***N.B. \* = mandatory field***

|  |  |  |
| --- | --- | --- |
| **Child or Young Person’s Details** | | |
| **Child’s First Name \*** | Given Name | |
| **Child’s Surname \*** | Surname | |
| **Child’s Previous Names** |  | |
| **Also Known As** | Calling Name | |
| **Date of Birth \*** | Date of Birth | |
| **Gender \*** | Gender(full) | |
| **NHS Number** | NHS Number | |
| **Name of School or Nursery \*** |  | |
| **Address of School or Nursery** |  | |
| **Postcode of School or Nursery\*** |  | |
| **Ethnicity \*** | Ethnic Origin | |
| **Child’s Main Language** | Main Language | |
| **Interpreter / Signer Required for Child?** | Yes | No |
| **Address including postcode\*** | Home Full Address (single line) | |
| **Telephone** | Patient Home Telephone | Patient Mobile Telephone |
| **Parent / Carer / Responsible Adult’s Details** | | |
| **First Name \*** |  | |
| **Surname \*** |  | |
| **Parent’s Main Language** |  | |
| **Interpreter / Signer Required for Parent?** | Yes | No |
| **Address** (if different to child) |  | |
| **Telephone \*** |  |  |
| **Email** |  | |
| **GP Details** | | |
| **Name** | Usual GP Full Name | |
| **Address** | Usual GP Organisation Name, Usual GP Full Address (single line) | |
| **Telephone** | Usual GP Phone Number | |
| **Email** | Organisation E-mail Address | |
| **Referrer Details** | | |
| **Name \*** | Current User | |
| **Role \*** |  | |
| **Address including postcode\*** | Organisation Name, Organisation Full Address (single line) | |
| **Telephone \*** | Organisation Telephone Number |  |
| **Email \*** | Organisation E-mail Address | |

**Section 3: Other Professionals known to the Child**

**Please state current multiagency professionals involved with child & family (e.g. health visitor, social care, preschool/school setting).**

**Name Agency Telephone Email**

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**[Section](file:///C:\\Users\\nelsonb\\AppData\\Local\\Temp\\EMISWebDocs7176\\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf" \l "Check2) 4:** **Reasons for Referral**

**\*\*\*\* YOU DO NOT NEED TO FILL IN EVERY SECTION \*\*\*\***

**Cross only the sections that relate to the area(s) of need and then add further details in sections 6-13 as required**

***Please click the adjacent section number to navigate to this section within the form***

|  |  |  |
| --- | --- | --- |
| **Referral need:** | **Cross X** | **Go to section** |
| [Speech, language or communication concern](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_4)s |  | [6](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section6) |
| [Eating/drinking and/or swallowing concern](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_5)s |  | [7](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section7) |
| [Occupational Therapy needs](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_6) |  | [8](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section8) |
| [Physiotherapy needs](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_7) |  | [9](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section9) |
| [Need for a community paediatrician’s appointment including neurodevelopmental concerns](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_8) |  | [10](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section10) |
| [Social communication concerns](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_9) |  | [11](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section11) |
| [Sensory concerns (e.g. hearing and vision](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_10)) |  | [12](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section12) |
| [Other](file:///C:\Users\nelsonb\boboea\AppData\Local\Temp\EMISWebDocs3368\Community%20Children%20Services%20Single%20REFERRAL%20FORM.rtf#_Section_11) (including behavioural and emotional concerns\*) |  | [13](file:///C:\Users\nelsonb\AppData\Local\Temp\EMISWebDocs7176\Single%20Point%20of%20Referral%20(SPOR)%20Form%20Camden%20Community%20Children's%20Services%202017.rtf#Section13) |

|  |
| --- |
| **What would you, as the referrer, like to happen and what outcome would you like to see from this referral?**    **(If the referrer is not the parent) What would the parent like to happen, and what outcome would they like to see from this referral?** |

**\*If the child’s only concern is related to mental health, please sent a referral letter to Joint Intake Services, Tavistock Clinic, 120 Belsize Lane, London, NW3 5BA, or call them on 020-8938-2638.**

**If there are Social Care concerns please complete a Common Assessment Form (CAF)** (*e.g. care, safety and protection, housing, emotional warmth, stability and family relationships, family history, family functioning (including wider family), employment and finances, community resources and social integration*)

**Please send all new Social Care referrals to the Multi Agency Service Hub (MASH):** [**LBCMASHadmin@camden.gov.uk.cjsm.net**](mailto:LBCMASHadmin@camden.gov.uk.cjsm.net) **or call 020 7974 1117 / 3317**

**If the child is already known to Social Care, please contact that service directly.**

**Section 5: Developmental History and Education**

| **Question** | **Comment** |
| --- | --- |
| **Please comment on the child’s achievement of their developmental milestones** |  |
| **Please add any educational information (e.g. ahead or behind of peers, requires support in class)** |  |

**Section 6:** **Speech, Language and/or Communication Concerns**

**What are your reasons for this referral? Please select the areas of need and give examples where appropriate.**

| **Area of need** | **Example or details of areas causing concern** (i.e. level of functioning and/or impact on the child e.g. child is frustrated or passive) |
| --- | --- |
| **Attention & Listening**  (e.g. are they able to sit still?, are they easily distracted?, group vs. individual) |  |
| **Understanding Language**  (e.g. do they follow instructions without help?, understanding of vocabulary) |  |
| **Using Communication**  How does the child indicate what they want either verbally or non-verbally? (e.g. gestures, words, sentences) |  |
| **Augmentative Communication Systems**  (e.g. electronic device, communication book) |  |
| **Speech Sounds**  (pronunciation –are they easily understood? Particular sounds difficult?) |  |
| **Other**  (please state e.g. voice / fluency) |  |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 7: Eating / Drinking / Swallowing Concerns**

| **Area of need** | **Details of concern, including impact on functioning where relevant** |
| --- | --- |
| **Child’s weight**  (e.g. under / overweight) |  |
| **Child’s ability to swallow safely**  (e.g. do they cough when they eat, have problems chewing foods, recurrent chest infections or reflux?) |  |
| **Child’s diet**  (e.g. do they only eat certain foods and/or avoid foods or meal times?) |  |
| **Other** |  |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 8:** **Occupational Therapy Needs**

| **Area of need** | **Details of concern or need, including impact on functioning where relevant** |
| --- | --- |
| **Self-Care**  (e.g. functional difficulties with dressing, eating, toileting) |  |
| **Leisure Skills**  (e.g. difficulties with poor co-ordination, ball skills, riding a bike) |  |
| **Functional Difficulties at nursery/school/college**  (e.g. handwriting, scissor skills  etc. *and/or* difficulties with organisational skills, attention or under/over reactivity to sensory information) |  |
| **Need for Adaptive Equipment in School**  (e.g. special seating) |  |
| **Need for Equipment in the Home** (e.g. special seating, toilet and bath aids, hoists etc.) |  |
| **Need for Assistive Technology**  (e.g. laptop for school work) |  |
| **Developmental Delay/extreme prematurity (under 5’s only)** |  |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 9:** **Physiotherapy Needs**

|  |  |
| --- | --- |
| **Area of need** | **Details of concern, including impact on functioning where relevant** |
| Concern(s) about gait |  |
| Physical concern |  |
| Neurological concern |  |
| Developmental concern |  |
| Balance and coordination difficulties |  |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 10**: **Neurodevelopmental Concerns / Paediatrics**

|  |  |
| --- | --- |
| **Reason for referral:** |  |
| **Established diagnoses:**(Please attach any relevant correspondence) |  |
| **Relevant medical background:**  (related to pregnancy/birth/hospital admissions/medication/allergies/growth/learning development/ hearing/vision) |  |
| **Relevant examination findings:** |  |
| **Would it be appropriate for this child to be seen in the paediatric safeguarding clinic at Crowndale?**  Yes  No  Please note, if you ticked yes:   1. This SPOR referral does not replace a referral/discussion with Camden Early Help/MASH. 2. Please ensure you have discussed any safeguarding concerns with your manager or the named health professionals for safeguarding children. 3. Please ensure the family/carers are aware that their child may be seen in the paediatric safeguarding clinic. | |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 11:** **Social Communication Concerns**

| **Area of need** | **Details of concern, including impact on functioning where relevant** |
| --- | --- |
| **Social interaction**  (e.g. failure to initiate or respond to social interactions, understanding and using emotions) |  |
| **Non-verbal communication**  (e.g. poorly integrated verbal and non-verbal skills, abnormalities in eye contact, lack of gestures) |  |
| **Social relationships**  (e.g.difficulty with developing, maintaining and understanding relationships) |  |
| **Other**  (e.g. does the child have any restricted repetitive patterns of behaviour) |  |
| **Are you requesting an ASD assessment?** | Yes  No |
| **If yes, have parents consented to an ASD assessment?** | Yes  No |

**Please attach SCAS form if requesting ASD assessment as well as all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 12: Sensory**

|  |  |
| --- | --- |
| **Area of need** | **Details of concern, including impact on functioning where relevant** |
| **Hearing loss / impairment**  (please give details of last hearing assessment/referral made if applicable) |  |
| **Visual impairment** |  |
| **Other** |  |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 13:** **Other Concerns**

**If the child’s only concern is related to mental health, please send a referral letter to Joint Intake Services, Tavistock Clinic, 120 Belsize Lane, London, NW3 5BA, or call them on 020-8938-2638.**

|  |  |
| --- | --- |
| **Area of need** | **Details of concern, including impact on functioning where relevant** |
| **Behavioural concerns** |  |
| **Emotional concerns** |  |
| **Other** |  |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Section 14: Other Information**

|  |  |
| --- | --- |
| **As the referrer, what is your own plan for on-going input to this family?** |  |
| **Which other relevant information should be considered?**  Birth history, where born, current and past medical history / medication (or please simply attach relevant documentation e.g. letters) |  |
| **Family and Environmental** (*please detail any relevant information about family medical history; family history and/or family functioning; housing, employment)***: Fill in if you have any information or concerns** |  |
| **Are there any safeguarding or vulnerability concerns?** |  |
| **If you are aware that the child being referred has been exposed to any of the following Adverse Childhood Experiences (ACEs), please indicate which ones here:**   * **Child maltreatment (e.g. verbal, sexual, physical abuse, and neglect)**   **A household where there has been**   * **Domestic violence** * **Mental illness** * **Drug use** * **A family member in prison** * **Parental separation** * **Alcohol abuse** | | |

**Please attach all relevant correspondence such as hospital letters, case notes to this form (electronic / SystmOne / MOSAIC etc.)**

**Parent / Carer / Practitioner Name** Current User

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date** Short date letter merged

**Send completed forms to:** [**adminspor.cnwl@nhs.net**](mailto:adminspor.cnwl@nhs.net) **Please, do not post this form.**