**Integrated Reviews**

**Criteria for Referral**

**(Please complete all sections of the form before submitting)**

**Child’s name……………………………………………………………………………………………………………………………**

**Child’s DOB……………………………… NHS no……………………………………………………….**

**Parent’s/Caregiver’s name……………………….……….……………………………………………………………………….**

**Address……………………...…………………………………………………………………………………………………………………….**

**Contact Number……………………………………………………………………….**

|  |  |
| --- | --- |
| **REASON FOR REFERRAL** | **OVERVIEW:** **Please include an overview of the reason for the referral** |
| **Delayed Speech** - | **Less than 50-200 words****Repetitive speech****Not responding to own name, consistently** |
| **Behavioural Concerns-**  | **Withdrawn****Not engaging in meaningful play****Constant hitting and aggression****Inappropriate behaviour****Repetitive behaviours (Flapping, Spinning ETC.)** |
| **Social and Emotional Concerns-** | **Lack of attachment with Parents and other children****Lack of eye contact****Persistent separation anxiety beyond 3 months** |

**Safeguarding concerns past or present?............................................................................................**

**Other services/agencies involved………………………………………… …………………………………………………………**

**Are there any pets in the home?.......................................................................................................**

**Has the referral been discussed and agreed with parent/caregiver?....................................**

\*Please note that each referral must be agreed with the parent/caregiver before being submitted to the

Community Nursery Nurse Team

Please send referral via email to

  clcht.childhealthinformationhubkcwf@nhs.net

 For any additional advice call the SPA (Single Point of Access) Health Visiting line: 020 8200 2500

 **Referrer sign:…………… ……………… …………………. Date……………………………………….**