



ADDITIONAL INFORMATION FORM TO ACCOMPANY CHILDREN'S SERVICES REFERRAL FORM

Baby aged from birth to 11 months

Date of Referral

Referrer

In order to help services appropriately accept and prioritize referrals, this form should be completed by the baby's parents or in consultation with them, and sent with the Children's Services Referral Form. Please also attach any health or other reports you have on your child

Child's Surname

Child's First Name

Date of Birth

Parents' names and contact details

BIRTH HISTORY

Length of Pregnancy

Weeks/days

Place of Birth

Birth Weight

Birth Length

Was your baby admitted to the neonatal unit? Yes No

Has your baby been in hospital at any time since they were born? Yes No

If Yes, for what reason?

Please give details of medications, hospital and nursing needs, breathing and feeding supports

Please provide your baby's up to date length, weight and head size centile scores from their growth chart if available.

TELL US ABOUT YOUR BABY'S DEVELOPMENT

Can your baby....

Grab a toy with either hand? Left Right Not yet

Grab both feet when lying on his or her back? Yes Not yet

Roll over... On to tummy On to back Neither yet

Tolerate lying on his or her tummy? Yes Not yet

Sit.... On his or her own Only with support Not yet

Crawl... On tummy On hands and knees Not yet

Does your baby pull to standing? Yes Not yet

Stand....	Without support <input type="checkbox"/> Only with support <input type="checkbox"/> Not yet <input type="checkbox"/>
Do you have any other concerns about your baby's movement such as being floppy or tense when you lift him or her?	
If so please give details:	
Is your baby able to fully open his or her hands including thumb? Yes <input type="checkbox"/> Not yet <input type="checkbox"/>	
Is your baby able to grasp and release a toy? Yes <input type="checkbox"/> Not yet <input type="checkbox"/>	
Does your baby use one hand more than the other? Yes <input type="checkbox"/> Not yet <input type="checkbox"/>	
Can your baby pass toys from one hand to the other? Yes <input type="checkbox"/> Not yet <input type="checkbox"/>	
If you have concerns about your baby's hand movements please give details:	
Do you have any concerns about your baby's weight or growth? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes please describe	
Please enclose any growth and weight charts.	
Describe your baby's daily feeding routine, times and size of feeds. How does your baby feed? How long does a breast or bottle feed take? If your baby has started spoon feeding, is it going well?	
Do you find feeding stressful? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes please describe	
Is your baby taking any specialised feeds, drinks or foods? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please give details	
Do you have concerns about your baby's sleep? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes please describe	
How do you know what your baby wants? e.g. does he or she look at you, cry when hungry, smile, reach out?	
Can your baby look at an object and follow it when it moves? Yes <input type="checkbox"/> Not yet <input type="checkbox"/>	
What kind of sounds does your baby make? e.g. happy sounds, sad sounds, types of cries, sounds like aah, babble such as bada, gaga	

Do you have concerns about how your baby's behaves? e.g. excessive crying, irritable, too quiet Yes No

If Yes please describe your concerns

Do you have concerns about your baby's ability to play and respond to play? Yes No

Please describe your concerns:

Do you think your baby is over-sensitive to noise, textures, movements or smells? Yes No

If Yes please give details

Do you have concerns about your baby's eye sight? Yes No

If Yes, give details of your concerns and result of any tests undertaken

Has your baby had a hearing test? Yes No

Please give details

Do you have any concerns about your baby's hearing now? Yes No

If Yes, give details of your concerns

Has anyone else expressed concern about any aspect of your baby's development? e.g. Doctor, Public Health Nurse, family members, childminder Yes No

If Yes please give details including who expressed the concern:

Is there anything else you would like to tell us about your baby?

Tell us about what he or she enjoys and can do, along with any concerns you have

What is your main concern and priority for your baby?

Safety and Risk Please give details of any issues which pose a significant risk to the health and wellbeing of your baby or of others.

Please give details of who completed this form

Form completed by:

Relationship to child:

Contact details:

Date: