



## ADDITIONAL INFORMATION FORM TO ACCOMPANY CHILDREN'S SERVICES REFERRAL FORM

Child/young person aged from 12 years to 17 years 11 months

Date of Referral:

Referrer:

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

Child's or Young Person's Surname

First Name

Date of Birth

Parents' names and contact details

**YOUR CHILD'S OR YOUNG PERSON'S DEVELOPMENT** Please note some questions may not be relevant

### 1. Movement (Gross Motor Skills)

Do you have any concerns about your child's or young person's ability to move around such as walking, running, jumping, and balancing?

Yes  No

If Yes give details including any assistance required such as crutches, wheelchair for distance

How does their difficulty with moving impact on their ability to do everyday tasks e.g. leisure and social activities, washing, dressing?

Have you noticed any recent changes in their ability to move or their level of fatigue? Yes  No

If Yes, please give details

Do you have any other concerns about their movement or gross motor skills?

### 2. Fine Motor and Hand Skills

Does your child or young person have difficulty using their hands such as handwriting, using scissors, picking up small items, using computers? Yes  No

If yes, give details

**3. Communication**

Does your child or young person have difficulty expressing themselves e.g. asking for help, describing events?

Yes  No

Do they have difficulty understanding people? Yes  No

Is it difficult to understand what they are saying? Yes  No

Do they have difficulty going along with a conversation if the other person changes the topic? Yes  No

Do they have any difficulty with understanding jokes or phrases such as 'I'm only pulling your leg'? Yes  No

**If Yes to any of the above questions please describe:**

Do they use technology or a computer to communicate? Yes  No

If yes please give further information on technology or computer use:

Do they have any issues with their voice e.g. prolonged hoarseness?

Do you have any other concerns about their speech, language, communication and voice?

**4. Social Interaction, Relationships and Leisure**

Do you have concerns about your child's or young person's ability to form and keep up relationships with others?

Yes  No

Please describe your concerns

Please describe any leisure or sport activities they take part in

**5. Daily Living Skills**

**5A. Food and Drink**

Do you have any concerns about your child's or young person's weight or growth? Yes  No   
 If Yes, give details

Do you have any concerns about how much food they eat or the range of foods they eat? Yes  No   
 If Yes, give details

Describe their daily food, drinks and mealtime routine

Do you have any concerns about how they are eating drinking or swallowing?  
 If yes please describe

Are mealtimes stressful? Yes  No   
 If Yes, describe

Are they on specialised drinks or foods? Yes  No   
 If Yes, give details

**5B. Bowel and Urinary Habits**

Are there any difficulties with toileting? Yes  No   
 If Yes, give details:

**5C. Personal Care, Dressing and Independence**

Do you have concerns about your child's or young person's ability to manage the following compared with others their age?

Dressing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Undressing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Washing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Brushing teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>
Organising belongings	Yes <input type="checkbox"/> No <input type="checkbox"/>	Getting ready for bed	Yes <input type="checkbox"/> No <input type="checkbox"/>
Getting ready for school	Yes <input type="checkbox"/> No <input type="checkbox"/>		

If Yes to any of the above give details

**5D. Sleep and Rest**

Do you have concerns about their sleep or ability to rest or relax? Yes  No

Do they have difficulty initiating activities or appear lethargic or tire easily? Yes  No

If Yes to either of these questions, give details

**6. Behaviour and Emotions.**

Have you concerns about your child's or young person's emotional wellbeing and behaviour?

At home  At school  Out and about

Please describe any concerns

**Do the following statements describe their behaviour and emotions? (Please tick the appropriate boxes)**

Frequent prolonged outbursts or meltdowns <input type="checkbox"/>	Aggressive <input type="checkbox"/>	Avoids certain activities or people <input type="checkbox"/>	Low mood <input type="checkbox"/>	Clingy <input type="checkbox"/>
Upset for seemingly minor things <input type="checkbox"/>	Withdrawn/too quiet <input type="checkbox"/>	Doesn't like change <input type="checkbox"/>	Frustrated <input type="checkbox"/>	Worries a lot <input type="checkbox"/>

If Yes to any of the above, how often does this occur? Daily  Weekly  Monthly  Less often

What impact does this have on them and on your family and what helps to prevent problems?

**7. Learning**

Do you have any concerns about your child's or young person's ability to learn? Yes  No

If Yes give details

Has anyone expressed any concern about their ability to learn such as a teacher, psychologist or family member?

Yes  No

If Yes give details of the concern and who expressed it

Are they having any difficulties keeping up with learning and school work? Yes  No

If yes please give details

Have they had any assessments e.g. NEPS?

***Please enclose with this form copies of any school or psychology reports you have on your child.***

Do they have extra learning support in school such as SNA, Special Education teaching? Yes  No

If Yes give details

## 8. Vision and Hearing

Does your child or young person have problems with eyesight or vision which cannot be corrected with glasses?

Yes  No

If Yes, give details

Do they attend a specialist service for their vision or hearing? Yes  No

If Yes, give details

## 9. Sensory Processing

If you have concerns about your child's or young person's sensitivity to any of the following, either avoiding, getting annoyed with or seeking out, please tick

Noise  Touch  Textures (such as fabrics)  Movements  Smells  Food  Lights

If you have ticked any of the above, please describe how this impacts on everyday life for your child and for you

**Is there anything else you would like to tell us?**

**Tell us what your child or young person enjoys and can do well, as well as those things they find difficult**

[Empty rectangular box for notes or observations]

**What is your main concern and priority?**

[Empty rectangular box for text response to the question above]

**Safety and Risk**

**Are there any issues which are a significant risk to their health and wellbeing or that of others, such as physical injury to self or others, refusal to eat?**

**Please give details of who completed this form**

**Form completed by:**

**Relationship to child:**

**Contact details:**

**Date:**