ADDITIONAL INFORMATION FORM TO ACCOMPANY CHILDREN'S SERVICES REFERRAL FORM

Child aged from 6 years to 11 years 11 months

Date of Referral:	**Referrer:**

In order to help services appropriately accept and prioritise 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 on your child

Child's Surname	**Child's First Name**	**Date of Birth**

Parents' names and contact details

YOUR CHILD'S DEVELOPMENT *Please note some questions may not be relevant for your child*

1. Movement and gross motor skills

Do you have any concerns about your child's ability to move around such as walking, running, jumping, balancing compared to other children their age?

Yes ☐ No ☐

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

How does your child's difficulty with moving impact on their ability to do everyday activities? e.g. washing, dressing, play

Have you noticed any recent changes in your child's ability to move or their level of fatigue? Yes ☐ No ☐

If Yes, please give details

Do you have any other concerns about your child's movement or gross motor skills?

2. Hand Movement and Fine Motor Skills

In comparison with other children their age can your child do the following?

Pick up small objects with finger and thumb	Yes ☐	No ☐
Play with construction toys such as building blocks or Lego	Yes ☐	No ☐
Use a pencil or pen to write	Yes ☐	No ☐
Use a scissors to cut paper	Yes ☐	No ☐
Open their lunchbox	Yes ☐	No ☐

If you answered No to any of the above questions or you have other concerns about your child's hand movement please give details

3. Communication, Speech and Language

Do any of the following describe your child? Please tick if Yes

My child has difficulty telling a story e.g. telling me about something that happened at school	☐
My child gets confused when I give them long instructions	☐
My child has difficulty holding a conversation with other children	☐
My child has difficulty holding a conversation with adults	☐
My child's speech is difficult to understand compared to other children	☐
My child likes to talk about particular topics to the exclusion of others	☐
My child has difficulty holding eye contact	☐
My child has difficulty understanding what is said to them	☐
My child does not consistently respond to their name	☐
My child has issues with their voice e.g. prolonged hoarseness	☐
My child has a stammer	☐

If you have ticked any of the above please give further details:

Does your child use technology or a computer to communicate? Yes ☐ No ☐

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

Please give details of any other concerns about your child's speech, language, communication and voice:

4. Social Interaction, Relationships, Play and Leisure

When playing does your child allow you or other adults to join in? Always ☐ Sometimes ☐ Never ☐

When playing does your child allow other children to join in? Always ☐ Sometimes ☐ Never ☐

Give details of any concerns about how your child plays with others

What toys and games does your child like to play with and how do they play with them?

Does your child engage in imaginative play e.g. pretend and make believe games?

What activities does your child like to do?

What activities in the community does your child take part in?

Does your child need extra help to play with others and if so what kind of help?

Please give any further comments about your child's play, friendships and activities:

5. Daily Living Skills

5A. Food and Drink

Do you have any concerns about your child's weight or growth? Yes ☐ No ☐

If Yes, give details

Please describe your child's usual meal, food and drink routine:

Do you have any concerns about how much your child eats or the range of foods they eat? Yes ☐ No ☐

If Yes, describe

Does your child have special feeding requirements? Yes ☐ No ☐

If Yes, describe

Do you have any concerns about ***how*** your child is eating, swallowing and drinking? Yes ☐ No ☐

If Yes, describe

Are mealtimes stressful? Yes ☐ No ☐

If Yes, describe

5B. Urinary and Bowel Habits

Does your child have any issues with toileting? Yes ☐ No ☐

If Yes please describe

5C. Personal Care, Dressing and Independence

Do you have concerns about your child's ability to manage the following compared with other children their age?

Dressing	Yes ☐ No ☐	Undressing	Yes ☐ No ☐
Washing	Yes ☐ No ☐	Brushing teeth	Yes ☐ No ☐
Organising belongings	Yes ☐ No ☐	Getting ready for school	Yes ☐ No ☐
Getting ready for bed	Yes ☐ No ☐		

If Yes to any of the above please describe your concerns

5D. Sleep and Rest

Do you have concerns about your child's sleeping routine? Yes ☐ No ☐

Do you have any concerns about your child's level of energy? Yes ☐ No ☐

If Yes to either of these questions give details

6. Behaviour and Emotions

Do you have concerns about your child's emotional wellbeing and behaviour?

At home ☐ At school ☐ Out and about ☐

Please describe any concerns

Do any of the following describe your child's behaviour? (Please tick if Yes)

Frequent prolonged outbursts or meltdowns ☐	Aggressive ☐	Avoids certain activities or people ☐	Excessive crying ☐	Clingy ☐
Upset for seemingly minor things ☐	Withdrawn or too quiet ☐	Doesn't like change ☐	Frustrated ☐	Worries a lot ☐

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

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

7. Learning

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

If Yes please describe

Has anyone expressed any concern about your child's ability to learn such as a teacher, psychologist or family member?

Yes ☐ No ☐

If Yes, give details of the concern and who expressed it

Is your child having any difficulties keeping up with learning and schoolwork? Yes ☐ No ☐

If Yes, give details:

Has your child had any assessments of their learning? e.g. NEPS

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

Does your child have any additional support in school, such as SNA, Special Education teaching? Yes ☐ No ☐

If Yes, give details :

8. Vision and Hearing

Does your child have vision problems which cannot be corrected with glasses? Yes ☐ No ☐

If Yes, give details:

Does your child attend a specialist service for their vision or for their hearing? Yes ☐ No ☐

If Yes, give details:

9. Sensory Processing

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

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

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

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

Tell us what your child enjoys and can do well, as well as the things they find difficult

What is your main concern and priority for your child?

Safety and Risk
Are there any issues which are a significant risk to the health and wellbeing of your child or 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:** **Please attach copies of any health or school reports**