Bath and North East Somerset Single Point of Entry Referral Form

This form is also available as a Word template.

Please contact the SPE administrator if you would like a copy of this.

Bath & North East Somerset Council

Please return this form, completed as fully as possible, to:
SPE Administrator
Child Health Department, Ground Floor
Midford House, St Martin's Hospital
Kempthorne Lane
Bath BA2 5RP
vcl.bathnesclinicccoordinationteam@nhs.net
Tel: 01225 731 548

Details of Child
Or attach label. Leave this section blank if these details are on an accompanying letter.

Child's Surname: **<Patient name>** Forenames <Patient name>

Date of Birth **<Date of birth>**

Family name if different to child's____

NHS No <NHS number> Please tick box if interpreter is needed.

Ethnicity <Ethnicity> First language <Main spoken language>

☐ Please tick box if interpreter is required, if yes what language ______________________________________

Address <Patient address>

Post code **<Patient address>** School / Pre-School <Patient School>

Mobile <Patient contact details> Home telephone <Patient contact details> Preferred telephone <Patient contact details>

Child's GP **<GP name> <GP details>**

Health Visitor/school nurse (if known)

Referral to:
These are the teams currently accepting referrals through the B&NES Single Point of Entry System.
If you are not sure where your referral should go, please refer to the Intake Team.
A team of clinicians will discuss the referral and ensure it is passed to an appropriate team.

Referrals from Schools: Please ensure you discuss your referral with the school nurse or educational psychologist. They may be able to help the child, seeking advice from professionals within the locality team, without the need for a full referral. Discussed with school nurse / educational psychologist? ☐ Yes ☐ No

☐ Paediatrician

☐ CAMHS (check new referral criteria)

☐ Speech and Language Therapy

☐ Children's Learning Disability

☐ Nursing Service

☐- Continence Service

☐ Dietician

☐ Occupational Therapy

☐ Physiotherapy

☐ School Nursing Service

This service is provided by Virgin Care, NHS Bath and North East Somerset CCG and Bath and North East Somerset Council.
Registered office: Virgin Care Limited, Lynton House, 7-12 Tavistock Square, London WC1H 9LT
Registered in England and Wales number: 5466033

Service provided by

☐ Audiology

☐ Intake Team

☐ Orthoptist

The referrer

Why are you making this referral?

Please give as much information as possible to enable locality professionals to make the best possible decision.
Continue on another sheet if needed or attach a letter.
Please send copies of additional information/reports as appropriate.

Child/young person

What do you want to happen as a result of this referral?

Parents/Carers

What do you want to happen as a result of this referral?

About the parents/carers

Name	Relationship	Contact details	Parental Responsibility
			☐ yes ☐no
			☐ yes ☐no

Please indicate which of these services are, or have been, involved with this child.

- ☐ Education Welfare
- ☐ Social Services
- ☐ Health Visitor
- ☐ Educational Psychology
- ☐ Vision
- ☐ Youth Offending Team
- ☐ Behaviour Support Services
- ☐ Inclusion/Learning Support
- ☐ Connexions
- ☐ Other please specify ____________________

For each agency currently working with the child/young person/family please provide the following details.
Use 2nd sheet if necessary.

Start date	Agency	Name and Role	Tel Contact Nos

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Service provided by virgincare

Important no referral can be accepted without the consent of the child or parent/guardian.

Please tick at least one box.

The child or parent/guardian has consented to this referral. Child ☐ Parent/Guardian ☐
I have discussed the referral fully with the child/parent/guardian as appropriate, making it clear that any referral to more than one team, or to the Intake Team, will be discussed by a team of clinicians before allocation.

Discussed with GP Yes ☐ No ☐

Signed_______________________________ Job Title_______________________________

Print Name _______________________________ Date _______________________________

Location _______________________________ Contact no _______________________________

Office use only

Entered on system _______________________________ on: _______________

For uniprofessional assessment, forward to _______________________________ on: _______________

Discussed at Intake Team meeting _______________________________ on: _______________

Decision: _______________ forwarded to: _______________ on: _______________

On call Dr _______________ Please indicate Community Paediatrician

or RUH Paediatrician

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