# INDIVIDUAL NEEDS REFERRAL FORM

| Name of Child | | | | | |
|---|---|---|---|---|---|
| Date of Birth | | | Sex (M/F) | | |
| Home Address | | | | | |
| Nationality | | Religion | | Ethnic origin | |
| Referred By | | Referral Date | | | |

| Parents / Guardians living at child's home address | | | | | | |
|---|---|---|---|---|---|---|
| Relationship to Child | | | | | | |
| Title | | | | | | |
| Forenames | | | | | | |
| Surname | | | | | | |
| Daytime Tel No | | | | | | |
| Mobile Tel No | | | | | | |
| Email Address | | | | | | |
| Preferred contact method | PHONE ☐ | EMAIL ☐ | POST ☐ | PHONE ☐ | EMAIL ☐ | POST ☐ |
| Siblings living at child's home address | | | | | | |
| Relationship to Child | | | | | | |
| Forenames | | | | | | |
| Surname | | | | | | |
| Date of Birth | | | | | | |
| DIAGNOSIS, CONDITION MEDICAL & OTHER SUPPORT NEEDS | | | | | | |
| What diagnosis, condition, medical needs or additional support needs does the child you care for have?<br>Please write as much information as possible to describe your child's support needs in detail. | | | | | | |

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Life is precious

| PLEASE SELECT ANY OF THE BELOW THAT IS APPLICABLE TO THE CHILD YOU CARE FOR: | | |
|---|---|---|
| ☐ Progressive/Chronic Illness | ☐ Seizures | ☐ Therapy (physio, OT etc) |
| <u>Technology Dependent</u> | <u>Feeding</u> | ☐ Sensory Impairment |
| ☐ Ventilator, trachy etc | ☐ NG Tube | ☐ Mental Health Problems |
| ☐ Feeding pump | ☐ Button e.g. Gastrostomy | ☐ Learning Disability |
| ☐ Intrathecal Baclofen or similar | <u>Disability Aids</u> | ☐ Autism Spectrum Disorder |
| ☐ Oxygen Dependent | ☐ Wheelchair Dependent | ☐ Other - Please state below |
| ☐ Medication Dependent | ☐ Orthosis e.g. foot, spinal | |
| ☐ Physical Disability | ☐ Hoisting Requirements | |

| MEDICAL | | |
|---|---|---|
| Please list all the medical professionals involved with your child's care. | Consultant | |
| | Consultant | |
| | Physiotherapist | |
| | SALT | |
| | OT | |
| | NHS Community Nurse | |
| | | |
| Other – please specify e.g. specialist nurses | | |
| | | |
| | | |
| | | |

| COMMUNICATION | |
|---|---|
| How does the child you care for express themselves and communicate? E.g. Makaton, BSL. | |
| Does the child you care for use a communication aid? If yes, what is it eg PECS. | |
| Does the child you care for have social communication issues?<br>If yes, please describe. | |
| Does the child you care for have physical communication issues?<br>If yes, please describe. | |
| Does the child you care for have difficulties in managing their feelings and emotions?<br>If yes, please describe. | |

| BEHAVIOUR | |
|---|---|
| Does the child you care for have any challenging behaviour which is likely to cause a problem while taking part in activities with other children?<br>If yes, can you describe what those behaviours are and how they are managed? | |

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| SENSORY PERCEPTION | |
|---|---|
| Does the child you care for have any sensory differences or difficulties?<br>Please describe what they are and how they affect your child e.g. coping with light or noise etc | |
| Please tell us how the child you care for can be assisted to cope with their sensory problems. | |
| EDUCATION | |
| What playgroup, nursery, primary or secondary school does your child attend? | |
| Named teachers involved with your child's care | |
| SOCIAL WORK | |
| Does your child have a named Social Worker?<br>Please provide details. | |
| OTHER AGENCIES | |
| Does your child have interaction or support from other agencies or organisations e.g. Befriend a Child, Home Start, CHAS?<br>Can you provide details. | |
| ADDITIONAL INFORMATION | |
| This section is to let us know if there is anything else about your child that you feel is important to tell us.<br><br>You can also tell us about your child's sibling(s). We have specific referral forms for siblings requiring support | |

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| CHILD SUPPORT NEEDS: TICK AS APPROPRIATE: | WHAT DO YOU HOPE TO ACHIEVE AS A FAMILY? |
|---|---|
| ACTIVITIES<br>☐ Family Group activities<br>☐ Short Stay Breaks<br>☐ 7 and under Group Activities<br>☐ Parent Carer Activities<br>☐ Sibling Activities<br>☐ Holiday Activities<br>SUPPORT<br>☐ Advocacy<br>☐ Managing feelings and emotions<br>☐ Information & Guidance<br>☐ 1:1 support<br>☐ Family Support<br>☐ Sibling Support<br>☐ Support parents/carers having difficult conversations with children<br>☐ Keeping memories safe<br>☐ Pre/ Post Bereavement support<br>☐ Observations<br>☐ Support with Multi-agency meetings | ☐ Meeting other families<br>☐ Increase Confidence<br>☐ Support to talk to children about difficult situations<br>☐ Work on strategies and techniques to manage feelings and emotions<br>☐ Help improve concentration<br>☐ Support to attend family activities<br>☐ More family themed activities<br>☐ Increased family time<br>☐ Pre-bereavement support<br>☐ Post bereavement support<br>☐ Signposting to other organisations<br>☐ Other please state |

| HOW DID YOU HEAR ABOUT CHARLIE HOUSE? | ONCE COMPLETED, PLEASE RETURN FORM TO: |
|---|---|
| ☐ Friend/Family<br>☐ Social Media<br>☐ Health Care Professional<br>☐ Educational Professional<br>☐ Social Work<br>☐ TV or Radio campaigns<br>☐ Newspaper or magazine publications<br>☐ Website<br>If other, please state: | LEIGH RYRIE<br>CHILDREN & FAMILY SUPPORT MANAGER<br>BALMORAL HOUSE, 74 CARDEN PLACE<br>ABERDEEN<br>AB10 1UL<br>leigh@charliehouse.org.uk |

I ________________________________confirm that I am the Parent/Carer for _____________________________________

By signing, I understand the reasons for the referral, the referral forms have been clearly explained to me and I am giving consent for this referral to be processed.

Charlie House recognises the value of your Personal Data and, as such, treat this with a high degree of care and security. By signing below, you give Charlie House consent to process your Personal Data in line with our Members Privacy Notice.

| SIGNATURE | |
|---|---|
| DATE | |