Referral Form

**Building Underdeveloped Sensory Systems**

**Date of referral**

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**Child / young person referred**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |

**Details of people living in the family / household**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child  |  |
|  |  |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child |  |

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child |  |
|  |  |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child |  |

**Contact information for parent(s) or carers**

|  |  |
| --- | --- |
| Name/s |  |
| Address |  |
|  |  |
|  |  |
| Telephone – Home Landline(can messages be left) |  |
| Telephone – Personal Mobile(can messages be left) |  |
| Telephone – Work(can messages be left) |  |
| Email addresses |  |
| Availability for calls/meetings |  |

**Referrer’s information**

|  |  |
| --- | --- |
| Name |  |
| Role |  |
| Address |  |
|  |  |
|  |  |
| Telephone numbers |  |
|  |  |
| Email address |  |
| Working days/hours |  |

**Main reason for referral**

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**Other agencies involved with the child and family**

|  |  |
| --- | --- |
| Agency/Organisation | Name, email address and contact telephone number |
| Social Care professionals |  |
| Name of School SENCO/Head of Year or teaching staff who know the child best |  |
| Other e.g. OT, Paediatrician, Physiotherapist |  |
| Is the child or family ***currently*** involved with other agencies providing mental health or therapeutic support? |  |
| Has the child or family ***previously*** accessed therapy? If so, what was the nature of that support, when was it offered and with whom? |  |

**Information about the child / young person**

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| Was there any history of drug and/or alcohol use during pregnancy? |
|  |
| Child’s current physical health and wellbeing |
|  |
| How does the child hold themselves and how do they move? E.g. When they stand or walk, is it a smooth, well co-ordinated movement? Do they seem to have good core strength? Are their movements floppy or jerky? Does their body look as if it’s working as one fluid unit? Is it well synchronised? Do arms and legs work helpfully together? What is their head position like? |
|  |
| Has the child had a neurodevelopmental assessment for ASC, FASD or ADHD? If so, what was the outcome? |
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**Information about current difficulties and outcomes being sought**

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| What would the family like help with?  |
|  |
| What does the referrer think is needed? |
|  |
| What are the referrer’s desired outcomes of any interventions provided?  |
|  |
| What are the parent’s desired outcomes of any interventions provided, and the child’s desired outcomes? |
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| --- |
| Where did you hear about BUSS? e.g. webinar, word of mouth, website etc |
|  |
| Please could you attach the adoption support assessment with parental permission. **YES/NO** |