

## Appendix 4 Referral Form for CYP Physiotherapy

*Please complete this form ideally typed but if not, in block capitals*

**Please note: Incomplete referrals will not be processed**

<b>Name:</b>	<b>Date of Birth:</b>
<b>Address:</b>	<b>Tel Home:</b>
	<b>Tel Mobile(s):</b>
<b>GP:</b>	<b>Gender:</b> Female/Male
	<b>NHS number:</b>
<b>Consent given to share information for this referral?</b> Yes/No	
<b>Consent to receive SMS text for appointment reminder</b> Yes/No	
<b>School/Nursery:</b>	
<b>Does the child/young person have an Education, Health and Care plan?</b> (please outline support provided or attach)	
<b>Does the child/young person have an Early Help Assessment?</b> (Please attach) Yes/No	

<b>Reason for referral:</b> (presenting condition)
<b>Diagnosis:</b> (if known)
<b>History of presenting condition:</b> (including parental/school concerns, pregnancy and birth history, achievement of motor milestones, etc)
<b>Relevant past medical history:</b>
<b>Has the child received physiotherapy input in the past:</b> Yes/No
If yes, detail where, who and input/advice given:
<b>What, if any, therapy equipment has been issued?</b>

<b>What interventions (related to this issue) have been tried/are being tried place and who is providing them?:</b> (e.g. school sensory circuits, motor groups, etc)	
<b>Family and Social History:</b> (e.g. home situation, cultural, social, safeguarding issues, known conditions in family, etc)	
<b>Interpreter required?:</b>	Yes/No
<b>If yes, which language:</b>	
<b>Any other relevant information:</b>	
<b>Other professionals involved (please name and give contact details):</b> (e.g. Speech and Language Therapy, Occupational Therapy, Health Visitor, Paediatrician, Social Work, Educational Psychologist, Psychologist, etc)	
<b>If you are making a referral to any other service(s) alongside this referral? If yes, please state which service(s):</b>	
<b>Referrer's name and Contact Details:</b>	
<b>Date of referral:</b>	

**Please return this form (ideally electronically) with any relevant reports to:**

Email address: [CCS-TR.therapyreferrals@nhs.net](mailto:CCS-TR.therapyreferrals@nhs.net)

Postal address: Children's Therapy Services,  
The Peacock Centre,  
Brookfields Hospital Campus  
Mill Road,  
Cambridge  
CB1 3DF

Tel: 01223 218065