## 

**CHILDREN’S PHYSIOTHERAPY REFERRAL FORM**

**PLEASE ENSURE THAT THIS FORM IS FILLED IN FULLY. IT WILL BE RETURNED TO YOU IF ITEMS ARE NOT COMPLETED. PLEASE CROSS OUT ANYTHING THAT IS NOT APPLICABLE.**

|  |  |
| --- | --- |
| **CHILD’S DETAILS Sex: M F Other** | **PARENT / CARER:** |
| **Date of Birth:** | **First Name:** |
| **NHS Number (if known):** | **Surname:** |
| **First Name(s):** | **Relationship to child:** |
| **Surname:** |  |
| **Address:** | **Address (if different from child)** |
| **Postcode:** | **Postcode:** |
| **Telephone:** | **Telephone:** |
| **Email address:** | **Is this a Looked After Child?** **Yes / No**  **If Yes, please provide details of who holds responsibility: ………………………** |
|  | **hold responsibility:** |

**GP:**

**Address:**

**………………………………………..**

**Nursery / School:**

**Teacher’s Name:**

**Language Spoken:**

**…………………………………………**

**Interpreter required? Yes / No**

**EHC Yes/ No**

**Known to Social Care Yes / No Early Help in Place Yes / No Lead………………………………….....**

**Named Social Worker and Base:………………………………………………………………………………………………..**

|  |
| --- |
| **Consent gained for referral: Yes No \**please note if consent has not been gained then the referral will be returned***  **Name of referrer:…………………………………………. Designation……………………………………………………**  **Referrer address………………………………………….. Referrer contact number…………………………………….**  **Referral date………………………………………………… Referrer signature………………………………………..……** |
|  |
|  |

**Health Information (Please refer to checklist on page 2)**

**Does the child have a specific health condition/ diagnosis/injury?** Yes / No

Please state …………………………………………………………

**Relevant History** (including Xray/scans/developmental history as appropriate) …………………………………………….

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**Please state the current concerns you would like to Childrens Physiotherapy to address?**

**……………………………………………………………………………………………………………………………………………**

**……………………………………………………………………………………………………………………………………………**

**Please state the current symptoms or functional limitations?**

**…………………………………………………………………………………………………………………………………………..**

**……………………………………………………………………………………………………………………………………………**

**Any other professionals involved (Please state name, profession and contact details):**

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**Checklist**

|  |  |  |
| --- | --- | --- |
| **MOULDING DEFORMITIES** | | **Information** |
| **Congenital muscular torticollis (head turning preference)/ Plagiocephaly (significant)** | **REFER ASAP** | **Leaflet available for parent information: head turning preference and plagiocephaly** [**APCP Leaflet**](https://apcp.csp.org.uk/parent-leaflets) |
| **Positional Talipes**  **DDH** | **Please refer to UHCW Orthopaedics** |  |
| **PREMATURE BIRTH (where possible for babies on the neonatal pathway, also include assessment/outcome from neo-natal unit)** | | |
| **Born pre 30 weeks or under 1000g** | **Refer all babies routinely** | **Please attach Badger report** |
| **Babies born between 30 & 36+6 weeks** | **Refer if has:**   * **Brain lesion on MRI (e.g. Grade 3 or 4 IVH or PVL)** * **or Grade 2 or 3 HIE** * **or Neonatal bacterial or Meningitis** * **or Herpes simplex encephalitis** | **Please attach Badger report** |
| **GAIT ANOMALIES** | | |
| **In-toeing / out-toeing** | **Refer if significant asymmetry and/or**   * **Pain.** * **Limp** * **Breech delivery NOT being monitored by hospital** * **Family history of DDH** | **Please consider referring for a Xray hip/pelvis if there are concerns re: asymmetry of gait +/\_ hip range of movement.**  **If symmetrical please refer to** [**APCP Leaflet**](https://apcp.csp.org.uk/parent-leaflets)  **Parent Leaflet- Intoeing Gait** |
| **Toe walkers** | **Refer if there is asymmetry and/or**   * **There is difficulty getting up from the floor.** * **Milestones not achieved at appropriate age or unable to climb stairs reciprocally aged over 4.** * **Walking was initially normal** * **Not able to put heels to floor in standing when in an upright posture and not over extending knees.** |  |
| **Flat Feet** | **Refer only if there is**   * **pain / limp** * **stiffness of the foot** | **If patient has symptomatic flat feet -consider referral for orthotic assessment if insoles needed**  **Flat Feet:** [**APCP Leaflet**](https://apcp.csp.org.uk/parent-leaflets) |
| **Musculoskeletal**  [APCP Paediatric MSK Warning Signs](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiIodSkx5v5AhUMCsAKHfY1AXAQFnoECAsQAQ&url=https%3A%2F%2Fapcp.csp.org.uk%2Fsystem%2Ffiles%2Fpaediatric_msk_warning_signs.pdf&usg=AOvVaw3TQ1g7RddDRjrULuD2BOrN) [**Right Path triage-guide-october-2017.pdf**](https://www.rightpath.solutions/media/1030/triage-guide-october-2017.pdf) | | |
| **Hip/Knee Pain** | **Please refer to physiotherapy if red flags have been excluded (see above)** | **Hip pathology (e.g SUFE, Perthes) can present with**  **referred pain to knee or thigh, limp and asymmetrical gait. Consider referral to Orthopaedics / Request for Hip X-Rays if asymmetrical joint ROM and sudden onset of symptoms.**  **Osgood-Schlatter’s: please provide the patient with the APCP leaflet for initial advice. If the patient’s symptoms do not improve after 6/52 please refer to physiotherapy.** [**APCP Leaflet**](https://apcp.csp.org.uk/system/files/osgood_schlatters_disease_2015.pdf) |
| **Back Pain** | **Please refer to physiotherapy if patient experiencing functional limitations due to back pain and no red flags are present.** | **Children with scoliosis / Neurological symptoms (sensory changes, radiculopathy) to be referred to Paediatric Orthopaedics for assessment.** |
| **Hypermobility** | **Refer if significant pain / delay in motor skills / impact upon functional abilities.** | **If concerns present re: possible connective tissue disorder consider referral to Paediatric Rheumatology.**  **Symptomatic Hypermobility:** [**APCP Leaflet**](https://apcp.csp.org.uk/parent-leaflets) |
| **Developmental Delay** | | |
|  | **Corrected for gestational age.**  **Contact physio for advice if unsure on 02476961455** |  |
| **0 – 6 months** | **Refer if persistent head lag, not bringing head and hands to midline** |  |
| **6 – 12 months** | **Refer if not rolling, not attempting to sit at 8 months.** |
| **12 – 18 months** | **Refer if not weight bearing or if not crawling or bottom shuffling.** |
| **16 – 21 months** | **If crawling and not weight bearing in standing, refer at 16 months. If not walking refer at 18 months.** |
| **18 months - 2 years** | **Refer if asymmetry of gait, bottom shufflers not walking.** |
| **2 years plus** | **Refer if not walking up/down stairs ,not running** |

A range of relevant resources are located on our website. [**www.covkidsphysio.co.uk**](http://www.covkidsphysio.co.uk)

For any queries please contact 02476961455

Please return via email to: [Referrals.ChildrensPhysicalHealth@covwarkpt.nhs.uk](mailto:Referrals.ChildrensPhysicalHealth@covwarkpt.nhs.uk)

Or

Please return via post to:

Wayside House,

Wilsons Lane,

Coventry,

CV6 6NY