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 **North / South / West (please delete)**

 **Integrated Service for Children with Additional Needs (ISCAN)**

 **Referral Form**

***Please complete in black ink. Please refer to the referral criteria before completing the referral form.***

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| **Child / young person’s personal details** |
| Name of child |  | D.O.B. |  |
| CRN number |  | NNN number |  |
| Child known as |  | Gender |  |
| Address and postcode |  | Telephone number |  |
| Nationality  |  | Home languageInterpreter required? |  |
|  Yes / No |
| Name of GP & surgery |  | Telephone number |  |
| School/nursery & contact name / email |  | Telephone number |  |
| No of nursery sessions per week |  | Flying Start | Yes / No |
| **Child / young person’s main carers** |
| Name | Relationship to Child / Young Person | Parental responsibility |
|  |  | Yes / No |
|  |  | Yes / No |
| **Referrer details** |
| Name of referrer (print): |
| Designation of referrer (print): |
| Address: |
| Email: | Tel No: |
| Signature of referrer: | Date:  |
| **Please tick which process is expected for the child / young person?** |
| ND Assessment | ASD | Yes / No |
| ADHD | Yes / No |
| ISCAN referral for two or more developmental needs  | Yes / No |
| **Please list required services below e.g. paediatrician, occupational therapist, speech & language** |
|  |
| **What is the question you are asking ISCAN to address?** |
|  |
| **Reason for referral & area of need for child / young person? Has the child been previously referred to ISCAN?** |
| Please include as much detailed information as possible, in relation to your own assessment, child & family expectations, and any previous diagnosis, referrals or interventions  |
| **Birth, development & medical history** |
|  |
| **Educational history** |
|  |
| **Family history – please list siblings and ages. Please note any siblings with additional needs** |
|  |
| **Current functional impact on child / young person within the home, school and the community?** |
|  |
| **Referrer’s expectations from this referral:** |
|  |
| **Parent’s expectations from this referral:** |
|  |
|  **Other agencies Involved including contact names if applicable:**(Reports from other agencies may be very helpful  in the assessment process and should be attached if available) |
|  |
| **Safeguarding the child / young person** |
|  | Child Protection | Looked After Child | CASP (Child in Need) |
| Is the child / young person on the child protection register? |  |  |  |
| Is any other child / young person in the family on the child protection register? |  |  |  |
| Please list: |
|  |
|  |
| **Relevant information and reports available:** **Please attach all up to date reports (if not uploaded to CWS) e.g. recent clinic letters and medical reports.** | Y | N |
| **SOGS (compulsory for pre-school referrals relating to developmental needs)** |  |  |
| **Relevant health professional e.g. health visitor reports, therapy reports** |  |  |
| **Neurodevelopment teacher questionnaire (compulsory for all ASD / ADHD referrals)** |  |  |
| **School / Educational Psychology Report / IEP / IDP etc** |  |  |
| **Observations (school, playgroup and nursery age referrals)** |  |  |
| **Parent report** |  |  |
| **Other (please specify)** |  |  |

|  |
| --- |
| **Return of Form** **By post:**  ISCAN North, Nevill Hall Children’s Centre, Brecon Road, Abergavenny, NP7 7EGISCAN South, Serennu Children’s Centre, Cwrt Camlas, High Cross, Rogerstone, NP10 9LYISCAN West, Caerphilly Children’s Centre, Heol Las, Cwrt Llanfabon, Caerphilly CF83 2WP**Please ensure that correct postage is applied as we are unable to collect items from the post office with insufficient postage.****By E-mail:**  North: ISCANSectorNorth.abb@wales.nhs.uk South: ISCANSectorSouth.abb@wales.nhs.uk West: ISCANSectorWest.abb@wales.nhs.uk**In the subject line you must enter: *ISCAN referral form*** **FAILURE TO FOLLOW THE ABOVE INSTRUCTIONS WILL RESULT IN DELAYS IN PROCESSING****If you have any difficulty completing the request form, please phone ISCAN:****North - 01873 733163 / 01873 733164****South - 01633 748003 / 01633 748004****West - 02920 867447****Lines are open between 9am – 4.30pm on Monday – Friday** |

 **Integrated Service for Children with Additional Needs Team (ISCAN)**

 **Consent Form**

**It is essential this form is completed by the parent / guardian / carer. Please use black ink**

**Name of Child: Child’s date of birth:**

Before your child / young person can be discussed at an ISCAN team meeting, the new General Data Protection Regulations (GDPR) state that we need your consent to do so, this is called ‘opt in’. If you agree to your information being held by the ISCAN Service, please tick the box. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please be aware that the ISCAN team meeting may include discussions about family members who have a role in the care and support of your child.

The information that you have given to complete the ISCAN referral is important to the ISCAN service. We believe the most important details are yours. We give you our assurance that it is our policy to respect your privacy and your information will remain confidential unless we are required to disclose by law. If at any time in the future, you would like to amend your consent status, please contact us.

Information collected will be kept safe and secure in line with the Data Protection Act 2018 and GDPR. Further information of how we collect, store and use information relating to patients can be found in the Privacy Notice on the Aneurin Bevan University Health Board internet pages- [Privacy Notice - Your Information, Your Rights](http://www.wales.nhs.uk/sitesplus/866/opendoc/325507)

**I have been informed by the referrer about the ISCAN service & what this referral means? Yes / No**

**I have read and understand the referral form and agree to the reason for referral Yes / No**

**I consent to information concerning my child’s care being discussed at the ISCAN team meeting Yes / No**

**Following the ISCAN team meeting, I consent to referrals being made to appropriate services**

**including health, education, social care and the voluntary sector Yes / No**

**I agree that my child / young person’s views will be considered as part of this process Yes / No**

**I understand that my child / young person’s referral will be kept securely on file and form**

**part of my child’s medical record Yes / No**

**I have seen the ISCAN parent information leaflet Yes / No**

**Signature of parent / guardian: Date:**

**Name of parent / guardian:**

**For professionals only whereby verbal consent is obtained, please confirm that you have read the following statement to the parent:**

The information that you give to me to complete the ISCAN referral form is important. We believe the most important details are yours. I assure you that the ISCAN service will keep the information you share safe and secure in line with GDPR.

You understand that we may share your information with, and obtain information about you from our ISCAN partners, for example, health, education, social care and the voluntary sector.

**Signature: Date:**

**For young people -** The information that you give to the ISCAN service to complete the ISCAN referral form is important. We believe the most important details are yours. We assure you that the ISCAN service will keep the information that you share safe and secure in line with GDPR.

You can find out more information on how we use your personal information here -[Privacy Notice - Your Information, Your Rights](http://www.wales.nhs.uk/sitesplus/866/opendoc/325507)

**Signature of young person Date:**