

**Integrated Community Paediatric Services (ICPS)**

Suffolk Communication Aids Resource Centre (SCARC)

Thomas Wolsey Ormiston Academy (TWOA)

Defoe Road, Ipswich, Suffolk, IP1 6SG

Telephone: 01473 744223

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**SCARC Referral Form**

**Information about the young person**

|  |  |
| --- | --- |
| Name |  |
| DOB |  |
| Address |  |
| Telephone |  |
| NHS Number |  |
| GP/ Surgery |  |
| Consultant |  |

**Next of Kin**

|  |  |
| --- | --- |
| Name of Parents/Guardians/ Carers |  |
| Telephone (if different from above) |  |
| Address (If different from above) |  |
| Would interpreters be helpful to support the assessment? If so, what language is required? eg BSL |  |
| E-mail  |  |
|  | **Yes** | **No** |
|  |  |

**Education/ Care Setting**

|  |  |
| --- | --- |
| Education/ Care Setting |  |
| Education / Setting Telephone |  |
| Education / Setting Address |  |
| Education / Setting E-mail (Admin) |  |
| Key Contact (SENCo/ Keyworker/ Class Teacher etc) | **Name** |  |
| **Job Title** |  |
| **E-mail** |  |

**Referrer Information**

|  |  |
| --- | --- |
| Date of referral |  |
| Name of referrer |  |
| Job title |  |
| Address |  |
| Telephone |  |
| Email |  |

**Purpose of Referral**

|  |
| --- |
|  |

**Medical Information**

|  |  |
| --- | --- |
| Diagnosis |  |
| Date of onset |  |

**Hearing**

|  |  |
| --- | --- |
| How would you describe the young person’s hearing? |  |
| Do they wear an aid for their hearing? | **Yes** |  | **No** |  |
| If so, where? | **Right:**  |
| **Left:**  |
| **Both:**  |
| Name of aid: |  |

**Vision**

|  |  |
| --- | --- |
| Does the young person have any known visual difficulties (including visual perception)?If yes, please explain. |  |
| Are glasses worn? |  |

Can the young person:

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Make their eyes work together? |  |  |
| Follow a moving object up and down with their eyes? |  |  |
| Follow a moving object left and right with their eyes? |  |  |
| Maintain gaze on a fixed target? |  |  |

**Sensory**

|  |  |
| --- | --- |
| Does the young person have any known sensory difficulties? If yes, please provide further details. |  |

**Mobility**

*Please complete with Multidisciplinary Team (MDT) including Occupational Therapy (OT) and Physiotherapy (PT)*

|  |  |
| --- | --- |
| Which position appears to enable greatest physical control? |  |
| How does the young person move around? | **Indoors** |  | **Outdoors** |  |

Seating (if relevant)

|  |  |  |
| --- | --- | --- |
|  | **Home Chair/ Wheelchair** | **School/ Setting Chair/ Wheelchair** |
| Name of chair/ Manufacturer |  |  |
| Serial number |  |  |
| Does the young person use a power wheelchair? If so, how is it controlled? I.e. self-drive |  |
| Is the current seating meeting their needs well? |  |
| Are any other positioning equipment used (e.g. standing frames, wedges, walker etc)? |  |

Motor Skills

|  |
| --- |
| *Please describe the young person’s most reliable motor skills and any equipment used to support this:* |
| Manual pointing |  |
| Lateral arm movement |  |
| Raise/lower arm |  |
| Extend/retract arm |  |
| Turning head (side to side) |  |
| Up/down head movement |  |
| Eye gaze |  |
| Other (please state) |  |

**Communication**

*Please complete with Speech and Language Therapist (SLT) if relevant*

|  |  |
| --- | --- |
| Expressive LanguageHow does the young person communicate?Please identify any communication/ software systems (AAC) used e.g. *gestures, Makaton signs, photos, symbols, voice output device, switches/ computer.**Please include any formal assessment results (if applicable)* |  |
| How does the young person make a choice? |  |
| Receptive Language (comprehension)What visual support/ AAC systems (if any) are being used to support young person in their classroom/ setting (including symbol software)?*Please include any formal assessment results (if applicable)* |  |
| Social communicationDoes the young person initiate communication with their peers and supporting adults? |  |
| Attention and listeningHow would you describe the young person’s attention and listening skills? |  |

**Interests**

|  |  |
| --- | --- |
| Young person’s Likes |  |
| Young person’s Dislikes |  |

**Education Details**

*Please complete with class teacher (CT)/ keyworker (If relevant)*

|  |  |
| --- | --- |
| Can you describe the young person’s literacy skills? (if applicable) |  |
| Does the young person have an Education Health & Care Plan (EHCP)?Please note details of SALT support identified on EHCP (if known or mentioned). |  |

**Aside from those already mentioned in the referral, please give details of those people/professionals who help support the young person.**

**Everyone below (along with the people detailed at the start of this referral form) will be invited to attend the assessment. We expect a member of staff from the young person’s setting, a family member(s) or carer(s) and the referrer to attend the assessment to help provide a full picture of the young person and how we can support them.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship to young person** | **Telephone** | **E-mail** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Further details**

|  |  |
| --- | --- |
| Days young person is attending the education/ care setting |  |
| Please note any forthcoming referrals to other services to support the young person |  |
| Is your young person awaiting transition (changing setting etc)? If so, please provide details, including any transferring setting.  |  |
| Does your young person have 1:1 education/ care support at setting/ home?If so, please provide name and contact details? |  |

**Please send a copy of this form via e-mail to:**

scarc@wsh.nhs.uk

**Our consent can be marked electronically on our clinical records at assessment so if pre-18;0 please obtain verbal consent from the parent/ carer prior to SCARC’s involvement.**

**The referrer will be contacted via e-mail to confirm receipt referral and the outcome.**