|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Before providing us with your personal data, please ensure you have read our privacy policy on healthhorizons.org.uk**  **Please tick this box to provide consent for us to collect, store and share your personal data**  [Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.] | | | | | | |
| **1. Information about the child / young person** | | | | | | |
| **Name** | |  | | | | |
| **Date of Birth** | |  | | | | |
| **Gender** | | Male Female | | | | |
| **NHS number** | |  | | | | |
| **Address** | |  | | | | |
| **Home phone** | |  | | | | |
| **Mobile number** | |  | | | | |
| **Email** | |  | | | | |
| **GP Name** | |  | | | | |
| **GP Address** | |  | | | | |
| **GP Phone number** | |  | | | | |
|  | | | | | | |
| **2. Family / Carer information** | | | | | | |
| **Mother’s name (and address if different to above)** | |  | | | | |
| **Father’s name (and address if different to above)** | |  | | | | |
| **Is the child adopted or looked after? Please provide any relevant orders…** | |  | | | | |
| **Who has parental responsibility?** | |  | | | | |
| **Has the person with parental responsibility given consent for this assessment to take place?** | |  | | | | |
| **Siblings:**  **Name**  **Date of birth**  **Continue as necessary….** | |  | | | | |
| **Any physical or mental health problems in the family?** | |  | | | | |
| **Significant others?**  **Please include relationship to child.** | |  | | | | |
|  | | | | | | |
| **3. Child/ Young person’s medical history** | | | | | | |
| **Does the child have any medical problems or identified syndrome / diagnosis? Please summarise below** | | | | | | |
| **Is the child taking any medication?** | |  | | | | |
| **Do they have any allergies?** | |  | | | | |
|  | |  | | | | |
| **4. Nature of child/ young person’s difficulties?** | | | | | | |
| **What are the main concerns about the child/young person?** | | | | | | |
|  | | | | | | |
| **What is the impact on the young person and on others?** | | | | | | |
|  | | | | | | |
| **Do you have any concerns in the following areas? If so, please describe** | | | | | | |
| **Attention and concentration** |  | | | | | |
| **Speech sounds** |  | | | | | |
| **Is the young person able to express themselves ok?** |  | | | | | |
| **Is the young person able to understand what you say to him/her?** |  | | | | | |
| **Social interaction** |  | | | | | |
| **Play skills** |  | | | | | |
| **Behaviour** |  | | | | | |
| **Sensory difficulties** |  | | | | | |
| **Gross motor and fine motor skills** |  | | | | | |
| **Hearing** |  | | | | | |
| **Vision** |  | | | | | |
| **Learning** |  | | | | | |
|  |  | | | | | |
| **5. What has been done to date?** | | | | | | |
| **What has been done already to support the child/ young person?** |  | | | | | |
| **Does the young person currently have the involvement from either CAMHS, social care, or the youth offending service? (please list as necessary)** | Name | | Agency | | Contact | |
|  | |  | |  | |
|  | |  | |  | |
| **What other services or professionals are involved?**  **(please list as necessary)** | Name | | Agency | | Contact | |
|  | |  | |  | |
|  | |  | |  | |
| **Is the child under a formal process e.g. early help, child in need, EHCP. Please provide details of the co-ordinator** |  | | | | | |
|  | | | | | | |
| **6. Education** | | | | | | |
| **Which school or nursery does your child attend?** |  | | | | | |
| **Are there are concerns reported from education?** |  | | | | | |
|  | | | | | | |
| **7. Risk assessment** | | | | | | |
| **Has there been any historical incidents of deliberate self-harm or suicidal ideation? Please provide dates.** |  | | | | | |
| **Does there continue to be any risks to the young person, to others (parents, siblings, teachers, professionals, others) or to property?** |  | | | | | |
| **Have emergency services been involved, if so when?** |  | | | | | |
|  |  | | | | | |
| **8. Neurodevelopmental Assessment** **Information** | | | | | | |
| **Please indicate if your family would accept an assessment at home, in a clinic setting and/or online. (Please note home assessments may incur travel expenses)** | Home | | | Clinic | | Online |
|  | | | | | | |
| **9. What outcome would you like from an assessment by Health Horizons Limited? Please provide as much information as possible.** | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **10. Consent** | | | | | | |
| Parents/carers of this child / young person have agreed to referral to this service and have given written consent below to exchange information between relevant agencies including health, education and children’s social care as appropriate | | | | | | |
|  | | | | | | |
| **11. Referrer Details** | | | | | | |
| **Name** | |  | | | | |
| **Any relationship to child/young person?** | |  | | | | |
| **Agency** | |  | | | | |
| **Address** | |  | | | | |
| **Email** | |  | | | | |
| **Phone** | |  | | | | |