



3 North Road, Stevenage, Hertfordshire, SG1 4AT



Hertfordshire Community
NHS Trust

REFERRAL FORM: 0 - 5-YEAR-OLDS

Please complete all 3 pages

PLEASE NOTE: Step2 is not a crisis service. If you are concerned about the immediate wellbeing risk to a child please call 111 or Single Point of Access on 0800 6444 101. If a child is seriously unwell or injured, call 999.

All fields are mandatory in order to process this referral

Child/Young Person Information

NHS No:

Name:

Gender at Birth:

Date of Birth:

Ethnicity:

Address:

Gender Identity:

Preferred Pronouns:

First Language:

Preferred contact method:

Religion:

Mobile No:

Email:

GP (Name, address, contact number):

Early years/nursery/school (Name, address, contact number):

Names of those who hold parental responsibility:

Parental contact details (if different from child/young person):

Referrer Information

Name and Title:

Date of referral:

Address:

Contact Number:

Email:



All fields are mandatory in order to process this referral

Consent to Referral

If the parent/carer or child does not consent to this referral we are unable to process it.

Parent/Carer Consent:

Parent/carer consent to referral.

Consent to contact parent.

Child consents to referral.

Reason for Referral

(Please refer to Step2 criteria document and website for further information.)

Parent/Carer Bonding.

Specific Phobia

Impact of previous domestic violence on parent/carer-child relationship.

Anxiety

Parent/carer struggling to support child with regulating emotions (not due to a neurodevelopmental need).

Other (please specify):

1. Describe how the difficulty is impacting your child and family life.
2. When/where do these difficulties occur?
3. What does the parent/carer want to be different after input from Step2?
4. What support has parent/carer accessed to support this difficulty? (Health visitor, family centre, support worker, parenting programme etc.)
5. Safeguarding
Are there any current or previous safeguarding / child protection concerns in relation to this family?

Is the family currently open to Children's Services? Yes No



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Neurodiversity/Learning Disability**Autism** (please tick the appropriate answer):

- No queries
- Diagnosis confirmed
- Awaiting diagnosis
- Assessment completed - no diagnosis

Learning difficulty: (please tick the appropriate answer):

- No queries
- Diagnosis confirmed
- Awaiting diagnosis
- Assessment completed - no diagnosis

ADHD (please tick the appropriate answer):

- No queries
- Diagnosis confirmed
- Awaiting diagnosis
- Assessment completed - no diagnosis

Any other neurodiversity (please tick appropriate answer):

- No queries
- Diagnosis confirmed
- Awaiting diagnosis
- Assessment completed - no diagnosis

Next Steps:

If your referral is accepted what would be your preferred method of assessment? (Please tick your choice)

- Face-to-Face
- Video
- Telephone

Are there any learning needs, sensory impairments, language barriers, or communication preferences for the family/child or young person? If yes, please give details.

- Yes
- No

THANK YOU FOR COMPLETING THE FORM**Please email completed form to: hct.step2referrals@nhs.net**