**Referral to Paediatric Chronic Fatigue Syndrome, Child and Family Service**

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | NHS No. |  |
| Address |  | Date of Birth |  |
| Home Telephone |  |
| Work Telephone |  |
| Email |  | Mobile Telephone |  |

**Referrer Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Clinician |  | Date of Referral |  |
| GP Practice |  | Dates Not Available |  |
| Address |  | Telephone |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required?: | Yes | [ ]  | No | [ ]  | Wheelchair access required?  | Yes | [ ]  | No | [ ]  |
| Language:  |  | Learning Disability:  |  |
| Hearing: |  | Other disability needing consideration:  |  |
| Vision: |  |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | [ ]  | Member of Military Family |  |  |  |

**School:**

|  |  |
| --- | --- |
| Recent school attendance history: |  |
| Are there any mobility problems? | Yes [ ]  No [ ]  |
| Date of onset of symptoms: |  |

**Paediatric Assessment:**

|  |  |
| --- | --- |
| Has a diagnosis of CFS been made? | Yes [ ]  No [ ]  |
| Have child and family been informed? | Yes [ ]  No [ ]  |
| Name of Consultant paediatrician managing care and reviewing progress:  |  |
| Date of next review appointment: |  |

|  |  |  |
| --- | --- | --- |
| **Reason for Referral to Child and Family Service?** (please tick all that apply) | Yes | No |
| **1**. For Mental Health assessment to assist with diagnosis | [ ]  | [ ]  |
| **2.** For Mental Health assessment where there is thought to be an additional mental health problem e.g.* School related anxiety
* General anxiety
* Depression
* Eating disorder
* Conversion disorder
* Severe or prolonged symptoms of chronic fatigue
* Significant family relationship difficulties
 | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |
| **3.** For a recovery programme | [ ]  | [ ]  |

**Further Information:**

|  |
| --- |
|   |

**Medical Problems:**

|  |
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|  |

**Allergies:**

|  |
| --- |
|  |

**Medication:**

|  |  |
| --- | --- |
|  |  |
|  |  |

Yours sincerely,

Sent electronically, no signature required

**Email to:** BSWCCG.routinesarumreferralcentre@nhs.net