**Complex Needs Health Visiting (CNHV)**

**Referral Form Lambeth and Southwark**

**Please email your referral to**: **gst-tr.complexneedshealthvisiting@nhs.net**

Complex Needs Health Visitors (CNHV) provide targeted, timely, intensive and coordinated support to families with children who have complex developmental needs. Our support is focused on children between the ages of 0-5 years with additional/complex health needs. We provide the healthy child programme (HCP) and enhanced Early Intervention programmes which are evidence based.

CNHV support parents and carers through the process of diagnosis, implementing therapy programmes, developing strong relationships with their children who have complex health needs and discussing developmental concerns.

**Model of service provision**

We work in partnership with families to support and empower them to meet the challenges presented by a child with complex health needs. The service provides a personalised care plan followed by agreed follow up contacts.

**We offer:**

* Specialist developmental assessments and interventions
* Pre and post diagnostic support for the child and family
* Contributions to multidisciplinary assessments and meetings with parents who have concerns relating to their child’s development
* Support children to access early education and contribute to Education and Health Care Plan (EHCP) as required.
* Continence assessment toilet training
* Sleep support
* Fussy eating / feeding support
* Managing challenging behaviour
* The delivering training/advice for colleagues and multi-disciplinary team

**The CNHVs receive referrals from professionals**

**Inclusion criteria**

* Children with **Complex Health Needs** aged 0-5 years old
* Child and family **MUST** reside in Southwark or Lambeth
* Antenatal diagnosis of a complex genetic conditions e.g. Down’s syndrome T21, T18, spinal bifida etc.
* Parent(s)/carers of special needs children who need emotional and wellbeing support. This must be following a development assessment by the health care professional (HCP)

**Please note that your referral may be rejected if all sections are not completed**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Child / young person details** *– Complete all sections.* | | | | | | |
| **Full name of child:** |  | | | | | |
| **Address :** |  | | | | | |
| **NHS Number:** |  | | | | | |
| **DOB:** | Age: If unborn, estimated date of delivery: | | | | | |
| **Gender:** | Male  Female  Unknown | | | | | |
| **Ethnicity:** |  | | | | | |
| **First language:** |  | | Will an interpreter be required?  Yes ☐ No ☐  Language : | | | |
| **Telephone / Mobile** |  | | Email | |  | |
| **School / Pre-school** |  | | | Address: | | |
| **EHCP** | Yes/No/Not Known | | | | | |
| **History, assessment diagnosis, and current support being received** |  | | | | | |
| **CPP/CIN/LAC** |  | Category | | | |  |
| **Referral discussed with Parent (please tick):** | Yes ☐ No ☐ Date | | | | | |

|  |  |  |
| --- | --- | --- |
| **Parents and siblings:** | | |
| |  | | --- | | Name | | Relationship | D.O.B./EDD |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Professionals involved: Contact Details (Tel/Email )** | | |
| |  | | --- | | **AHPs (SLT, OT, Physio)** | |  |  |
| **Social Worker** |  |  |
| **SEND/SEN** |  |  |
| **Others** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer’s Details:** | | | |
| Referrer’s name and job role |  | Date of referral: |  |
| Referring team/agency and address: |  | | |
| Contact number/email |  | | |

**You will be notified by email when the referral has been accepted and we aim to contact the family/carer within 10 working days**