

## CST Referral and Consent Form

New Referral or Updating Records? *		Referrer's name *	
Select relevant impairment / difficulty *		Referrer's relationship to child / young person *	
Date *		Referrer's e-mail address *	

**Personal Information**

First name of child / young person *	Address of child / young person *
Middle name	
Surname *	Postcode *
Name the child / young person is known by	Borough of Residence *
Date of birth (dd/mm/yyyy) *	First language of the child / young person *
Gender *	Other language 1
Ethnicity of child / young person *	Other language 2
Is the child / young person an asylum seeker? *	NHS No.
Is the named child / young person disabled? *	Is the named child / young person registered disabled? *

1) Name of parent / carer *		Address (if different from child / young person)	
Relationship to child / young person *		Telephone no. *	
E-mail address *		Mobile no. *	
Interpreter required? *		Interpreter language	
Interpreter: comments / requirements		If 'Other', please specify the language	

2) Name of parent / carer		Address (if different from child / young person)	
Relationship to child / young person		Telephone no.	
E-mail address		Mobile no.	
Interpreter required?		Interpreter language	
Interpreter: comments / requirements		If 'Other', please specify the language	

3) Name of parent / carer		Address (if different from child / young person)	
Relationship to child / young person		Telephone no.	
E-mail address		Mobile no.	
Interpreter required?		Interpreter language	
Interpreter: comments / requirements		If 'Other', please specify the language	

4) Name of parent / carer		Address (if different from child / young person)	
Relationship to child / young person		Telephone no.	
E-mail address		Mobile no.	
Interpreter required?		Interpreter language	
Interpreter: comments / requirements		If 'Other', please specify the language	

1) Name of sibling		1) Date of birth (dd/mm/yyyy)	
2) Name of sibling		2) Date of birth (dd/mm/yyyy)	
3) Name of sibling		3) Date of birth (dd/mm/yyyy)	
4) Name of sibling		4) Date of birth (dd/mm/yyyy)	
5) Name of sibling		5) Date of birth (dd/mm/yyyy)	
6) Name of sibling		6) Date of birth (dd/mm/yyyy)	
7) Name of sibling		7) Date of birth (dd/mm/yyyy)	
8) Name of sibling		8) Date of birth (dd/mm/yyyy)	
9) Name of sibling		9) Date of birth (dd/mm/yyyy)	
10) Name of sibling		10) Date of birth (dd/mm/yyyy)	

Has the child / young person got an Education, Health and Care Plan (EHCP)? *	
---	--

Summary of visual / hearing needs / concerns \*  
(Important: Please attach any medical reports available to support referral as this speeds up the referral process)

Other special needs / comments

**Professionals involved with the child / young person**

Name of Paediatrician	<input type="text"/>	Name of Hospital	<input type="text"/>
Name of GP	<input type="text"/>	Name of GP Surgery	<input type="text"/>
Name of Health Visitor	<input type="text"/>	Name of Health Centre	<input type="text"/>
1) Name of Therapist	<input type="text"/>	1) Type of Therapist	<input type="text"/>
Name of Hospital	<input type="text"/>	If 'Other Therapist', please specify	<input type="text"/>
If 'Other', please specify	<input type="text"/>		
2) Name of Therapist	<input type="text"/>	2) Type of Therapist	<input type="text"/>
Name of Hospital	<input type="text"/>	If 'Other Therapist', please specify	<input type="text"/>
If 'Other', please specify	<input type="text"/>		
3) Name of Therapist	<input type="text"/>	3) Type of Therapist	<input type="text"/>
Name of Hospital	<input type="text"/>	If 'Other Therapist', please specify	<input type="text"/>
If 'Other', please specify	<input type="text"/>		
4) Name of Therapist	<input type="text"/>	4) Type of Therapist	<input type="text"/>
Name of Hospital	<input type="text"/>	If 'Other Therapist', please specify	<input type="text"/>
If 'Other', please specify	<input type="text"/>		

Is the child/young person known to Social Care? \*

**Parental / Carer Consent**

I agree to the Children's Sensory Team working with my child.

I agree to Children's Sensory Team working with other professionals to support my child's needs.

I am in agreement for my child to have mobility / habilitation session both in and out of the school premises with two adults present (if required).

I agree that information may be passed, where necessary to Harrow Council Support Services and Health Professionals.

Please check this box to confirm that parents have consented to this information and agree with the statements above. \*

**General Data Protection Regulation**

In accordance with the General Data Protection Regulation (2018), the London Borough of Harrow will use the data gathered through this referral solely for the purpose of assessing the named child or young person in order to meet their sensory needs. The information will be shared with partner agencies in order to make appropriate provision to meet the child or young person's identified needs.

In some cases, the London Borough of Harrow may use the information for other purposes if it has a legal duty to do so, to provide a complete service to the child or young person, to prevent and detect fraud or if there is a risk of serious harm or a threat to life.

The London Borough of Harrow may also use and disclose information, that does not identify individuals, for research and strategic development purposes. Please see the further information on Harrow Councils' Local Offer, Privacy Notice for the Children's Sensory Team.

To find out more about the way we handle your data please visit <http://www.harrow.gov.uk/privacy>

**What To Do Now**

1) **Save this form.** (Educational Settings / Health Settings: Please ensure you apply a suitably complex password to the document or send via Egress.)

2) **Email this form along with the 'CST Access to Medical Records Consent Form' to the recipients below:**

(You can copy and paste the email addresses all together)

[Helen.Forbes-Low@harrow.gov.uk](mailto:Helen.Forbes-Low@harrow.gov.uk)

[Mandy.Devine@harrow.gov.uk](mailto:Mandy.Devine@harrow.gov.uk)

[CSTBusinessSupport@harrow.gov.uk](mailto:CSTBusinessSupport@harrow.gov.uk)

3) **Add 'CST Referral and Medical Consent' in the subject heading of the email.**

4) **Attach the form and any relevant medical reports / documents with the email.**

**Please note that for a referral to be accepted, you MUST also submit the 'CST Access to Medical Records Consent Form'.**

Thank you.