***Appropriate referrals***

✔ The South West Cleft service provide specialist support (and accept referrals) for individuals and/or families with concerns directly related to cleft/velopharyngeal insufficiency (VPI) or its treatment.

✘ We do not accept referrals for issues known to be unrelated to cleft/VPI. For example: cognitive assessments; diagnosis of autism/ADHD; coping with other physical conditions. In such cases, appropriate local services should be discussed with the GP and/or attached Paediatrician/Consultant.

✘ We do not accept referrals for severe/acute mental health problems or significant personal risk (i.e. harm to self or others). In such cases, the appropriate local services should be discussed with the GP. Where such issues coexist with cleft/VPI related issues, we may be able to offer support for these only once satisfied these more global concerns are being/have been appropriately managed.

***Making a referral- information for patients and staff***

This referral form is the preferred route for patients returning to the SW Cleft Service to be documented and actioned. However, if you have difficulty completing the form and require support to do so, please call the administration team on 0117 342 1177 to provide the information requested over the phone.

Please complete all sections of this form, otherwise it may be rejected.

***Completed Referrals***

1. All referrals received will be triaged by the Cleft MDT. Referrals deemed inappropriate will be returned to the referrer with accompanying explanation.

2. All referrals must include GP details so that the South West Cleft Service can obtain medical history following a referral being accepted.

**This form must be completed by patient:**

Should you wish to discuss before submitting, please call 0117 342 1177.

|  |
| --- |
| Patient Details |
| Name (first name and surname)  |  |
| Date of Referral |  |
| NHS Number (if known: staff must include) |  |
| Date of Birth (DD/MM/YYYY) |  |
| Address |  |
| Phone Number |  |
| GP details (we require these details ahead of any appointments being made in the Cleft service) |  |
| Type of Cleft (if known) |  |
| Preferred language |  |
| Interpreter needed? (language and dialect if applicable) |  |
| Referral Details |
| Review requested from (delete as appropriate) | Psychology Speech Therapy Restorative Dentistry Orthodontics Surgery Other (please detail) |
| Reason for referral (brief description of case/difficulties) |  |
| Additional relevant information (e.g. past cleft operations, location, dates) |  |
| Please state cleft team the patient was previously under |  |
| If given the choice, which clinic would patient prefer to attend (delete as appropriate) | Bristol, Gloucester, Exeter, Plymouth, Truro. |
| Time sensitivity (i.e. dates of relevant events/visits/surgery/urgency) \* |  |
| Has patient (16+) consented to referral? (delete as appropriate) \*\* | Yes – Patient has consented.No – Referral not discussed.No – Referral refused. |
| Referrer Details (if not patient) |
| Your Name |  |
| Role/Relation to patient (if applies) |  |
| Address (work address if staff) |  |
| Phone |  |
| Email |  |

\* Please note that we do not provide support (or accept referrals) for severe/acute mental health problems or significant personal risk (i.e. harm to self or others). In such cases, the appropriate local services should be discussed with the GP. Where such issues coexist with cleft/VPI related issues, we may be able to offer support for these only once satisfied these more global concerns are being/have been appropriately managed.

\*\* Please note that unless a referral has been discussed with and consented to by a patient/family, we will **not** contact them to offer an appointment. However, we may still be able to offer psychological input via attending an MDT clinic or discussing a case with you.