# Herefordshire Children’s Occupational Therapy Team

# REFERRAL FORM

# Important:

* Has the child/young person been previously known to our service? **Yes / No**
* Please complete **ALL** sections of this form. Incomplete forms will be returned to the referrer.
* Please refer to our referral guidelines when completing this form.

| **CHILD’S/ YOUNG PERSONS DETAILS** |
| --- |
| Child’s/Young person’s name: |
| Date of birth: |
| Male or female – please indicate: |
| **Parents/carers name:** |
| NHS number: |
| Address: |
| Post code: |
| Telephone number: |
| Mobile number: |
| Email address: |

| **Please obtain Parent/Carer Consent to make this referral**(Referrals without consent will not be reviewed) |
| --- |
| I am aware of the reason for this referral and consent to the referral being made. I understand that this referral may be discussed and shared with other services if it is felt appropriate (listed below) in order for additional or alternative service referrals to be made. I consent for information to be shared for this purpose.**Parent Signature**: **or Verbal consent from (name of parent**): The paediatric services which this referral may be passed to are: Physiotherapy, Occupational Therapy, Portage, Speech and Language Therapy, Health Visitors and School Nurses. |

| **Is the child/young person a ‘Looked After Child’?**  |
| --- |
| Please indicate **Yes/No to the above ………..** If yes, provide Social Worker name and contact details:…………………………………………………………Are there any safeguarding concerns: Yes / No  |

| **Preferred language** |
| --- |
| Preferred language – please indicate:Interpreter required: **Yes/No** Ethnic Origin:  |

| **GP details** |
| --- |
| GP name:GP address:Telephone number:  |

| **Diagnosis/relevant medical history** |
| --- |
| Diagnosis:Relevant history: |

| **Referral details (Referrals accepted from Health Care Professionals, Social Care Teams and Education)** |
| --- |
| Referrer name (PRINT):Referrer address:Profession:Telephone number:Email address:Signature of referrer:Has consent for this referral been agreed: **YES/NO** |

| **School details**  |
| --- |
| School name:Teachers name:Telephone number:Does the child have an EHCP: **YES/NO** |

| **Other professionals involved**  |
| --- |
| Name:Profession:Contact details:Name:Profession:Contact details: |

| **Re-referrals**  |
| --- |
| If there is a significant change in the child’s Occupational Performance needs or a change in commitment to therapy (child or family) a referral can be made.If this is a re-referral, please explain the reason below: |

| **Functional difficulties** |
| --- |
| **Are the functional difficulties in line with the perceived developmental potential of the child/young person?** **Yes / No (please circle as appropriate – see referral guidelines)**  |

| **REASON FOR REFERRAL** **Self-care Occupations:****For below: Please Specify the occupational performance difficulties you would like Occupational Therapy to support** |
| --- |
| Bathing: |
| Washing: |
| Toileting: |
| Dressing: |
| Using cutlery: |
| Self-care skills i.e. nail cutting, hair brushing, tooth brushing: |

| **PLAY/LEISURE** **For below: Please Specify the occupational performance difficulties you would like Occupational Therapy to support** |
| --- |
| Is the child able to Participation in leisure activities |

| **PRODUCTIVE/SCHOOL OCCUPATIONS****For below: Please Specify the occupational performance difficulties you would like Occupational Therapy to support** |
| --- |
| Tool use in nursery/school:i.e. holding pencil, scissors, ruler |
| PE participation:i.e. Ball skills, balance, movement, understanding rules  |
| Other occupational performance barriers to accessing the curriculum i.e. focus and attention: |
| Academic attainment levels: |

| **PHYSICAL ENVIRONMENT****For below: Please Specify the occupational performance difficulties you would like Occupational Therapy to support** |
| --- |
| Access to property and facilities |
| Transfers |
| Seating for function |

**If you are referring on behalf of a school it is also important that a member of staff can be available to discuss the child’s strengths and difficulties, progress and needs if and when the Occupational therapist visits the school**

| **FOR SCHOOL REFERRALS ONLY:****For below: Please Specify the occupational performance difficulties you would like Occupational Therapy to support** |
| --- |
| Please indicate what support school staff would be able to provide for this child’s ongoing Occupational Therapy recommendations: |
| Frequency and duration of support that can be made available per week: |
| Name of person(s) supporting this child |
| Name of lead contact for this child and their role: |

**Give details of strategies and advice already given/intervention already completed prior to this referral:**

**Please see referral guidelines regarding the importance of this.**

| **Please specify below:** |
| --- |
| Early help: |
| Learning support: |
| Educational psychologist: |
| Movement programme: |
| Professional assessment and advice: |
| 12 week school intervention programme**(This needs to be completed prior to referral. See referral guidelines).** |

**PLEASE SEND THIS COMPLETED FORM TO: wvt.paediatricptotreferrals@nhs.net**

**Other Comments:**