**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: | Address: |
| D.O.B: M/F | Post Code: |
| Parent/Carer’s Name: | Tel No: |
| NHS No: | Mobile No: |
| Email address: |  |

Is the child/young person a ‘Looked After Child’? **Yes/No**

If yes, provide Social Worker name and contact details:…………………………………………………………

Preferred language: Interpreter required **Yes/No** Ethnic Origin:

**GP DETAILS**

|  |  |
| --- | --- |
| GP Name: | GP Address: |
| Tel No: |

**DIAGNOSIS/RELEVANT MEDICAL HISTORY**

|  |  |
| --- | --- |
| Diagnosis: | Relevant History: |

**REFERRER DETAILS** (Referrals accepted from Health Care Professionals, Social Care Teams and Education.)

|  |  |
| --- | --- |
| Referrer Name: (PRINT) | Referrer Address: |
| Profession: | Tel No/Mobile: |
| Signature of Referrer: | Date: |
| Has consent for this referral been agreed: **Yes/No** | |

**SCHOOL DETAILS**

|  |  |
| --- | --- |
| School Name:  Tel No: | Teachers Name: |

**OTHER PROFESSIONALS INVOLVED**

|  |  |
| --- | --- |
| Name: | Name: |
| Profession: | Profession: |
| Contact Details: | Contact Details: |

|  |  |
| --- | --- |
| Name: | Name: |
| Profession: | Profession: |
| Contact Details: | Contact Details: |

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

**REASON FOR REFERRAL Give details of the specific occupational performance concerns for this**

**child/young person:**

**Are the functional difficulties in line with the perceived developmental potential of the child/young person? Yes / No**

**Self-care Occupations:**

|  |  |  |
| --- | --- | --- |
|  | **✓** | **Please Specify** |
| Bathing |  |  |
| Washing |  |  |
| Toileting |  |  |
| Dressing |  |  |
| Using Cutlery |  |  |
| Self-care skills  i.e. nail cutting, hair brushing |  |  |
| Other |  |  |

**Play/Leisure:**

|  |  |  |
| --- | --- | --- |
|  | **✓** | Please Specify |
| Participation in leisure activities |  |  |
| Skills required to access play |  |  |
| Motor coordination |  |  |
| Other |  |  |

**Productivity/School Occupations:**

|  |  |  |
| --- | --- | --- |
|  | **✓** | Please Specify |
| Tool use in nursery/school  i.e. holding pencil, scissors, ruler |  |  |
| Planning and organisation |  |  |
| Dressing skills |  |  |
| PE participation |  |  |
| Other occupational performance barriers to accessing the curriculum |  |  |

**Physical environment:**

|  |  |  |
| --- | --- | --- |
|  | **✓** | Please Specify |
| Access to property and facilities |  |  |
| Safety |  |  |
| Transfers |  |  |
| Seating for function |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| FOR SCHOOL REFERRALS ONLY: | **✓** | Please Specify |
| 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: |  |  |

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

**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 |
| Early help |  |  |
| Learning support |  |  |
| PD Outreach |  |  |
| Educational Psychologist |  |  |
| Movement programme |  |  |
| Professional assessment and advice |  |  |
| 12 week school intervention programme  **(This needs to be completed prior to referral. See referral guidelines).** |  |  |
| Other |  |  |

**PLEASE SEND THIS COMPLETED FORM TO:** paediatric.ptotreferrals@nhs.net