**Children’s Occupational Therapy Referral Form**

**Paediatric Rehabilitation Service**

**Please complete all fields; incomplete forms will be returned**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | | | **DOB:** | | **Gender:** |
| **NHS Number:** | | | | | | | |
| **Address:** | | | | | **Postcode:** | | |
| **Telephone:** | | | | | **Mobile:** | | |
| **Email:** | | | | | | | |
| **Ethnicity:** | | **Religion:** | | | **Language:** | | **Interpreter needed Y/N** |
| **Main carer:**  **Relationship with child:** | | | | | | | |
| **Other carers with parental responsibility:**  **Address if different:** | | | | | | | |
| **GP Name: GP Surgery Address:** | | | | | | | |
| **Does this child or the child’s family pose a risk to a lone worker:  Yes No** | | | | | | | |
| **Other relevant information** (cultural, social, home situation, safeguarding plan*)*  **Parental Consent for OT referral:  Yes No** | | | | | | | |
| **Educational Setting: School Year:** | | | | | | | |
| **Nursery  Mainstream school  Special school  Independent school  Home education**  **Is child making educational progress as expected  Yes  No**  **If no please specify:**  **Name of School/Nursery:** | | | | | | | |
| **EHCP:  Yes  No**  **Caseworker Name: Contact Number:** | | | | | | | |
| **SenCo Name:** | | | | | **Contact Details:** | | |
| **Diagnosis or primary area of difficulty:** | | | | | | | |
| **Past Medical History/Birth History:** | | | | | | | |
| **Other professionals involved** | | | **Yes/No** | **Name and Trust/Authority** | | | |
| Physiotherapist | | |  |  | | | |
| Paediatrician | | |  |  | | | |
| Speech and Language Therapist | | |  |  | | | |
| Social worker | | |  |  | | | |
| Health visitor | | |  |  | | | |
| Visual Impairment Teacher or Specialist Teacher | | |  |  | | | |
| Other | | |  |  | | | |
| **What are the child’s functional difficulties? Please tick the relevant box(es). If more than one difficulty identified, please state which is the primary area for initial input.**  Fine Motor  Daily Living Skills  Access to school environment/nursery environment  Physical Disability  Equipment needs (including seating)  Related to a planned surgery (please include date if known) | | | | | | | |
| **Please state the reason for the referral which relates to above ticked box:**  **What interventions (related to the above points) have been tried or are currently in place?**  **What were the outcomes?** | | | | | | | |
| **Additional views of parent/different areas of concern** **that they identify:**  **Child’s views?**  What is the **desired outcome** from OT assessment/intervention? | | | | | | | |
| **Referrer details** | | | | | | | |
| Name: |  | | | | Designation: |  | |
| Date of referral: |  | | | | | | |
| Address: |  | | | | Telephone: |  | |
| Email: |  | | | | | | |

Please return this form with any available reports to:

Postal address:

Children’s Therapy Team

Rehabilitation Services

The Queen Elizabeth Hospital

Gayton Road

King’s Lynn

Norfolk

PE30 4ET

Electronic copy of this form can be sent to: [qehkl-tr.paediatrictherapyreferral@nhs.net](mailto:qehkl-tr.paediatrictherapyreferral@nhs.net)