**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