**Children’s Occupational Therapy Referral Form Education**

*( West Staffordshire)*

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| Child’s full name |  | | | | | | | | | | | |
| Date of Birth |  | | | | Gender | | | |  | | | |
| Who has parental responsibility for this child? | Name: |  | | | Relationship: | | | |  | | | |
| Home Address (inc postcode) |  | | | | | | | | | | | |
| Parent/carer’s email Address |  | | | | | | | | | | | |
| NHS Number (if known) |  | | | Telephone: 1 | | | |  | | | | |
| Telephone: 2 | | | |  | | | | |
| Language spoken at home |  | | | Interpreter required: | | | | Yes | | | | No |
| Language? | | | |  |
| Method of communication preferred by family (please tick all that apply) | Text | | Email | | | Phone | | | | Letter | | |
| GP (Mandatory) |  | | | GP Address and postcode | | | |  | | | | |
| Medical History & Early Developmental History |  | | | | | | | | | | | |
| Vision, hearing, known allergies, medication |  | | | | | | | | | | | |
| Medical Diagnosis |  | | | | | | | | | | | |
| What evidence of the diagnosis do you have?  *Please enclose a copy* |  | | | | | | | | | | | |
| Educational Diagnosis  e.g. Dyslexia, Learning Difficulties |  | | | | | | | | | | | |
| School/ Nursery Name  And address (inc postcode) |  | | | | | | | | | | | |
| School Telephone Number |  | | | | | | | | | | | |
| SENCO Name |  | | | | | | | | | | | |
| SENCO Email address |  | | | | | | | | | | | |
| Class teacher |  | | | | | | Year Group | | | |  | |

**Who is CURRENTLY involved in supporting this child and family?**

*(include health, education, social care and private services and any services where the child is waiting to be seen)*

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| Service name | Name, address & telephone number | Date seen / due to be seen |
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Who has seen the child/family in the **past** but is **no longer actively** involved?

*Please give details and dates when last seen*

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| Service name | Name, address & telephone number | Date last seen |
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| **Has the child seen an Occupational Therapist before?** *If so who / when / why?* |
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| **Please attach the Child’s IEP, pupil passport, or equivalent if they have one. If not, please describe any additional support the child is receiving, even if this is provided informally.** Please continue on separate sheet where necessary |

**For children at reception age and below**

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| **At what level is the child working?** | | | |
|  | **Birth – 3 years** | **3 – 4 years** | **Reception** |
| **Communication and language** |  |  |  |
| **Physical development** |  |  |  |
| **Personal, social and emotional development** |  |  |  |
| **Literacy** |  |  |  |
| **Mathematics** |  |  |  |
| **Understanding the World** |  |  |  |

**For children in year 1 and above**

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| **At what level is the child working?** (please tick) | | | | |
|  | **Exceeding age appropriate expectations** | **Working at age appropriate expectation** | **Working a little below age expectations** | **Working significantly below age expectations** |
| **Maths** |  |  |  |  |
| **Reading** |  |  |  |  |
| **Ideas and content of writing** |  |  |  |  |
| **Physical execution of writing / pre-writing skills** |  |  |  |  |
| **Physical education** |  |  |  |  |
| **Science / Topic** |  |  |  |  |

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| **Please describe the child’s strengths/ interests** |
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| **What daily activities does the child have difficulties with?** |
| **SELF CARE**  Managing meals, snacks and drinks –  Dressing –  Bathing –  Toileting –  Other – |
| **SCHOOL / NURSERY WORK-( in relation to their age expectations )**  Mark Making/Pencil –  Pre-scissor/Scissors -  Ruler -  Handling equipment/Toys –  Moving around school (including playground, toilet and dining access) -  Other- |
| **Play / Leisure**  Riding a bike -  Accessing playground equipment -  Other - |
| **What have you done to support these difficulties as part of your graduated response and differentiated teaching?** |

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| **Are any of these areas impacting the child’s function?** | |
| Learning ability  Behaviour  Language skills  Social/communication skills  Peer relationships  Emotions / mental health | Anxiety  Physical skills  Attention & concentration  Impulsivity  Unusual sensory responses  Repetitive obsessions |

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| **Do the parents/caregivers have special requirements? (eg physical disability, anxiety, mental health concerns)** |
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| **As a referrer What are your priorities for this child?** |
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| **What are the child and family’s priorities?** |
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**If you are a school making a referral for a child below school year 7, please complete the below.**

**PRIOR TO REFERRAL A MOTOR PROGRAM NEEDS TO BE COMPLETED AT SCHOOL FOR A MINIMUM OF 6 WEEKS. PLEASE ATTACH EVIDENCE OF THE PROGRAMME.**

**This MUST NOT be done for children with any physical disabilities (eg such as cerebral palsy, muscular dystrophy or arthritis). If in doubt please call the department before beginning a motor programme.**

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| Which motor program has been used at school, for how long? | | | |
|  | | | |
| How many sessions were delivered? | | | |
|  | | | |
| Date Started |  | Date Completed |  |
| What progress was seen? | | | |
|  | | | |

Please attach any assessments or record forms you completed as part of the child’s motor program.

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| REFERRER’S NAME |  |
| REFERRER’S TEL NUMBER |  |
| SIGNATURE |  |
| JOB TITLE |  |
| DATE COMPLETED |  |

**Consent:**  
*I declare that this referral has been shared with the parent / person with parental responsibility and their consent has been secured for me to make this referral.*

Name of the person with Parental Responsibility

Date that the person with Parental Responsibility consented to referral:

**Please note that incomplete referrals will not be accepted.**

**Please send the referral form to:**

[**ChildrensOTsouth@mpft.nhs.uk**](mailto:ChildrensOTsouth@mpft.nhs.uk)Telephone: 01785 221664

**PLEASE DO NOT MARK THE REFERRAL AS PRIVATE AS IT IMPACTS ON THE VISIBILITY IN THE SHARED INBOX**