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

Name:

DOB:

Gender: M/F

NHS Number:

Address:

Postcode:

Telephone:

Mobile:

Consent to receive SMS text for appointment reminder ☐ Yes ☐No

Ethnicity:

Religion:

Language:

Interpreter needed: ☐ Yes ☐No

Main carer:

Relationship with child:

Other carers with parental responsibility: Address if different:

GP Surgery:

Does this child or the child’s family pose a risk to a lone worker: ☐ Yes ☐No

Other relevant information (cultural, social, home situation)

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

Statement of SEN: ☐ Yes ☐No

Caseworker Name:

Contact Number:

Senco name:

Contact details:

Diagnosis or primary area of difficulty:

Involved:

*(please give name if known)*

Other professionals:

☐ Physiotherapist

☐ Paediatrician

☐ Speech and Language Therapist

☐ Social worker

☐ Health visitor

☐ Visual Impairment Teacher or Specialist Teacher

☐ Other *(please give details)*

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

☐ Physical Disability

☐ Sensory

☐ Co-ordination difficulties, please state if referring to physiotherapy

☐ Moving and Handling

☐ Equipment needs (including seating) in education setting

Please state the reason for the referral which relates to above ticked box:

What interventions (related to this issue) have been tried or are currently in place (home and/or school/nursery)?

What was the outcome?

Please attach any relevant reports. If previously seen by Occupational Therapy, when was the last contact?

Parent’s level of concern about the issue for which referral is being made.

☐ High

☐ Moderate

☐ Low

Additional views of parent / different areas of concern that they identify:

Child’s views?

What is the Desired outcome from OT assessment/intervention?

Safety Are there any safety issues/ risks for the child or others (arising from child’s needs)? Please specify:

Referrer details

Name:

Designation:

Address:

Postcode:

Telephone:

Email:

Parental consent to share:

Share in: ☐ Yes ☐No

Share out ☐ Yes ☐No

Please return this form with any available reports to: #

Children’s Occupational Therapy

Administration Zone A,

Floor 1 City Care Centre

Thorpe Road

Peterborough

PE3 6DB

For any enquiries Tel: 01733 847166