Office Use Only	***Not accepted***
Referral accepted: Yes / no	Out of area/Not Coventry GP
Clinic code:	Inappropriate
Priority level: 1 2 3	Incomplete/more information required
Signed: Date:	Recommend that you refer to……
Name:	Recommend that you access….

NHS
Coventry and Warwickshire Partnership
NHS Trust

CHILDREN'S OCCUPATIONAL THERAPY REFERRAL FORM

PLEASE ENSURE THAT THIS FORM IS FILLED IN FULLY. IT WILL BE RETURNED TO YOU IF ITEMS ARE NOT COMPLETED. PLEASE CROSS OUT ANYTHING THAT IS NOT APPLICABLE.

CHILD'S DETAILS **Sex: M F**

Date of Birth: .....

NHS Number (if known): .....

First Name(s): .....

Surname: .....

Address: .....

.....

Postcode: .....

Telephone: .....

Email address: .....

PARENT / CARER:

First Name: .....

Surname: .....

Relationship to child: .....

Address (if different from child)

.....

.....

Postcode: .....

Telephone: .....

Is this a Looked After Child? Yes / No

If Yes, please provide details of who holds responsibility: .....

GP: .....

Address: .....

.....

Nursery / School:

.....

Teacher's Name:

.....

Language Spoken

.....

Interpreter required Yes / No

Known to Social Care: Yes / No CAF in Place Yes/ No CAF Lead……

Named Social Worker and Base:……

Ethnic Origin (Please tick)

	White British	(A)		Other mixed	(G)		Black African	(N)
	White Irish	(B)		Asian- Indian	(H)		Other Black	(P)
	Other White	(C)		Asian- Pakistani	(J)		Chinese	(R)
	White & black Caribbean	(D)		Asian- Bangladeshi	(K)		Other Ethnic group	(S)
	White & black African	(E)		Other Asian	(L)			
	White & Asian	(F)		Black Caribbean	(M)		Not stated	(Z)

Name of referrer:…… Designation……

Referrer address…… Referrer contact number……

Referral date…… Referrer signature……

Health Information - Does the child have a specific health condition/ diagnosis? **Yes / No**

If so – what diagnosis?.....

Please state if the child was born prematurely and how many weeks gestation:……

Please state if there were any complications during pregnancy, birth or early years?
.....
.....
.....

Any other professionals involved:
.....
.....
.....

Children's Occupational Therapists work with children and families when a child has a difficulty fulfilling their potential in their daily occupations.

This form can be completed by either a child's parent/carer or school/nursery or another professional.

Area of occupational need	**What difficulties is the child experiencing?** - **What support do they currently have to complete a task?** - **What is the specific difficulty?** - **How could an Occupational Therapist help the child?** - **Please list any strategies/interventions already trialled**
Self-care- e.g washing, dressing, eating, drinking, toileting, sleeping	
Productivity – e.g. school/nursery, playing, mark making, handwriting, holding objects, organisation, attention	

Leisure – e.g. accessing the community, socialising and attending groups/hobbies.			
Moving and Handling – Please can you tell us if a child and/or carers require equipment or support for moving and handling?		**Equipment -** Does the child currently have any other equipment at home or school and is it meeting their needs?	
What would you like the outcome of our involvement to be?			

We will share information with other health professionals as appropriate
<u>I give consent</u>

- to an assessment by the Occupational Therapy Service as appropriate for my child — **Yes / No**
- for my child to be seen in school/nursery even If I am unable to be present — **Yes / No**
- for my child to be seen by a OT student under the supervision of a qualified OT — **Yes / No**
- for information to be shared with other professionals (inc. school/local authority) — **Yes / No**
- for my child to be photographed / videoed for clinical purposes — **Yes / No**
- to be contacted via:
  - * email — **Yes / No**
  - * text message — **Yes / No**
  - * voice mail messages — **Yes / No**

(please ensure all contact details are correct on the front page)

Signed: ..... (Parent/guardian) Print Name: .....

Date: .....

When we receive a referral, we will write to you to let you know and we may ask that you call us and book in a time to carry out a telephone appointment over the phone. The telephone appointment is where a therapist will call you to discuss in more detail the concerns you have raised. We will then decide on the best way to support your child.

A wide range of relevant resources are located on our website. **www.covkidsot.co.uk.**

Please return this form to: Children's Occupational Therapy Service, First Floor Paybody Building
C/O City of Coventry Health Centre
2 Stoney Stanton Road, Coventry, CV1 4FS