Coventry Children and Young People's Occupational Therapy Service
REFERRAL FORM

Important:

Has the child/young person you are referring been seen by our service within the last 12 months?

If **NO,** please complete **ALL** sections of this form

If **YES,** please complete sections **A, B and E** of this form

A CHILD'S DETAILS

Child's Name: M / F

……

D.O.B:

……

Parent's/Carer's Name(s):

……..

……..

NHS No:

……

Address:

……

……

……

……

Postcode: ……

Tel No/Mobile No:

……

……

Is the child/young person a Looked After Child? **Y / N**

Is the child/young person awaiting Hospital Discharge: **Y / N** Date of Discharge: ……..

Preferred Language:…….. Interpreter? **Y / N** Ethnic Origin: ……..

REFERRER DETAILS (We have an open referral system therefore anyone can refer, including families)

Referrer Name**:**

……..

Position:

……..

Referrer Address:

……

……

Tel No/Mobile: ……...

……

SCHOOL DETAILS

Signature of Referrer:

……

Date of Referral:

……

School Name:

……

Address:

……

……

Tel No: ……..

SENCO:……

GP DETAILS

GP Name:

……

GP Address:

……

……

……

Tel No:

……

CONSULTANT DETAILS (If appropriate)

Consultant Name:

……

Address: ……

……

……

Tel No:

……

B REASONS FOR REFERRAL

What is the specific difficulty/concern that you would like Occupational Therapy to help with?

What do you want the outcome of our involvement to be?

Please identify any strategies and advice already tried:
BEAM **Home Programmes** **Attending Parent Education Session**

OT specific training received

Any Other Information:

School Referrals Only: Please attach evidence of strategies used e.g. I.E.P, following training or programmes e.g. BEAM. Please give reasons why strategies used have not worked and/or what additional support you now require:

(If you would like to provide us with any additional information, please attach)

C OTHER RELEVANT INFORMATION

How many weeks gestation was the child/young person born at? ……

Did the child/young person achieve developmental milestones? **Y / N**
If no, please describe difficulties

Does the child/young person have a diagnosis? **Y / N**
If yes, please give details

Are there other professionals involved with the child/young person?

Name:
Profession:
Tel No:

Name:
Profession:
Tel No:

Name:
Profession:
Tel No:

Name:
Profession:
Tel No:

D Please circle and describe your main concerns for the child/young person in the relevant areas below:

ROUTINE and MOTIVATION

Emotional Well Being **Self Esteem** **Motivation** **Routine** **Confidence**

Organisation **General Behaviour**

Please describe **main** concerns:

SELF CARE SKILLS

Eating/drinking **Toileting** **Bathing** **Dressing** **Brushing Teeth/Hair**

Please describe **main** concerns:

SCHOOL SKILLS

Handwriting **Using Scissors** **Attention** **Organisation** **School Work**

Please describe **main** concerns:

PLAY/LEISURE SKILLS

Playing with Toys **Playing with Others** **Following Instructions**

Awareness of Safety **Clumsiness** **Tires Easily**

Please describe **main** concerns:

PHYSICAL and SOCIAL ENVIRONMENT, including access

Moving around the environment **Moving and Handling** **Bathing** **Toileting**

Seating **Access to Community/ Resources** **Floor Time**

Please describe **main** concerns:

E PARENT / CARER CONSENT

I give permission for my child to receive an Occupational Therapy assessment: **Y** / **N**
I give permission for a questionnaire to be sent to my child's teacher when appropriate: **Y** / **N**

Parent Name (please print):……

Parent / Carer Signature:…….. **Date**:……..

Significant elements of our resources are located within our website.

If you <u>do not</u> have access to the internet, please tick here ☐

N.B
We are only able to provide translated information via the post.

You will receive details of our website and unique log-in information for the child/young person once we have processed your referral. You will then receive access to specific resources. You can access our website for general information at the following address: www.covkidsot.co.uk. Our website will also provide you with up to date information about the service and current estimated waiting times.

Please return to:

Children and Young People's Occupational Therapy
Children's 4th Floor
City of Coventry Health Centre
2 Stoney Stanton Road
Coventry
CV1 4FS

Tel: (024) 7696 1455
Fax: (024) 7696 1565

Please ensure you have completed <u>all</u> sides of the form fully to avoid delay and assist us in prioritising the child/young person's needs.

<u>We cannot accept incomplete forms and these will be returned to the referrer</u>

THANK YOU.