Office Use Only

Referral accepted: Yes / No
Clinic code:
Priority level: 1 2 3
Signed: Date:
Name:

Not accepted

Out of area/Not Coventry GP
Inappropriate
Incomplete/more information required
Recommendation:

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.

THIS FORM CAN BE COMPLETED BY EITHER A CHILD'S PARENT/CARER OR SCHOOL/NURSERY OR ANOTHER PROFESSIONAL.

CHILD'S DETAILS Sex: M F	**PARENT/CARER:**	
Date of Birth:.....	**First Name:**	**GP:**.....
NHS Number (if known):	**Surname:**.....	**Address:**.....
First Name(s):	**Relationship to Child:**	.....
Surname:.....	.....	**Nursery/School:** .....
Address:.....	**Address (if different from child)**.....	.....
.....	.....	**Teacher's Name:** .....
Postcode:.....	.....	.....
Telephone:	**Postcode:**.....	**Language Spoken:** .....
Email Address:	**Telephone:**	.....
.....	.....	**Interpreter Required? Yes/No**

Is this a Looked After Child? Yes / No **If Yes, please provide details of who holds responsibility** .....

.....

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 Africa	**(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 yes, please state:
Birth history; Was your child born at full term? If not, how many weeks gestation? How was the birth? e.g. C-section Was any support required after Birth? e.g. Special Care Baby Unit.	
Developmental history; At what age did your child… Roll…….. Sit……. Crawl…….. Walk…… Talk (started using single words)…….	Learn to ride a scooter? ..... Learn to ride a bike? …….. Learn to swim? …… Toilet trained? .....
Are there any other professionals/services involved/working with child/young person?	
Does your child use / have any specialist equipment e.g. wears glasses, seating, toileting or walking aids?	

Please liaise with school or nursery to complete the following relevant sections with regards to your child's learning levels:

For nursery age children	**Beginning**	**Beginning Plus**	**Working Within**	**Working Within Plus**	**Secure**	**Secure Plus**	**Level of progress being made currently?**
Physical Development: Moving and Handling							
Physical Development: Health and Self Care							
Literacy: Reading							
Literacy: Writing							
Maths: Numbers							
Maths: Shapes, Space and Measure							

For Primary School Age children	**Beginning**	**Beginning Plus**	**Working Within**	**Working Within Plus**	**Secure**	**Secure Plus**	**Level of progress being made currently?**
Reading							
Writing							
Spelling							
Maths							

For Secondary School Age children	Grade achieving	Target Grade	Attitude to Learning	Level of progress being made currently?
English				
Maths				
Science				
P.E				
Other Subjects:				

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 Level of participation in washing, dressing, eating, drinking, toileting, sleeping	
Productivity – e.g. school/nursery, playing, mark making, handwriting, holding objects, organisation, attention, daily routine	
Leisure Does your child engage in any extra-curricular activity? What does your child like to do in their spare time?	
What are the main concerns you hope OT can help with?	
Parents/Carers View:	
Childs View:	

We will share information with other health professionals as appropriate
I give consent

- 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 an outcome and any next steps to arrange an appointment.

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

For up to date information on Community resources please see **www.coventry.gov.uk/localoffer**

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