Sutton Health & Care
Community Services

NHS

REFERRAL FOR CHILDREN'S OCCUPATIONAL THERAPY

Please complete this form in full as incomplete forms will be returned which will delay the referral

CHILD'S DETAILS

Title: Forename(s): Surname:

☐ M ☐F NHS Number: Date of Birth:

Address (incl. postcode):

Daytime contact number: Alternative contact number:

School/Nursery/Day Care: Year:

ETHNICITY

☐ White British	☐ Any other mixed background	☐ Black/ Black British Caribbean
☐ White Irish	☐ Chinese	☐ Black or Black British African
☐ Any other White	☐ Asian or Asian British Indian	☐ Any other Black groups
☐ Mixed:White&Black Caribbean	☐ Asian or Asian British Bangladeshi	☐ Any other ethnic group
☐ Mixed: White & Black African	☐ Asian or Asian British Pakistani	☐ Declined to state ethnic origin
☐ Mixed: White & Asian	☐ Any other Asian background	

PARENT/GUARDIAN S / NEXT OF KIN'S DETAILS (if applicable)

Name: Relationship to child:

Daytime contact number:

Address if different to child:

GP'S / HEALTH VISITORS DETAILS

Date of referral: GP's Name:

Contact number: Fax number :

Surgery address: Health Visitor:

NHS.net email address:

REFERRER'S DETAILS (if not GP)

Name: Job title:

Contact address: Date of referral:

Contact number:

Signature: **The referral will not be accepted unless it is signed by a professional who is involved with the child**

Other professionals involved:

GENERAL NEEDS OF THE CHILD

Is an interpreter required, what language is required? ☐ No ☐ Yes, language:

Language used in the home:

Can the family access written information e.g. appointment letters, leaflets? ☐ No ☐ Yes ☐ Unsure

Does the family have access to the internet?

Does the child have a learning disability? ☐ No ☐ Yes

Any current medication?

Is the child subject to/or ever to your knowledge had a Child Protection/in Need Plan? Yes No

Is there a CAF in place?

Has the child previously been seen by an Occupational therapist? If so, when and by whom?

Did patient / carer consent to referral and assessment: ☐Yes ☐No, please state reason:

Referral Information

Please describe main concerns / difficulties:

Self Care Skills (e.g. eating, dressing, toileting)

Hand Skills (e.g handwriting, pencil skills, scissors, use of two hands together)

Is the child left handed? ☐ Right handed? ☐

Gross Motor Skills (e.g balance, ball skills, playing with toys, postural control)

Sensory Issues (e.g sound, touch, body awareness, sensory seeking behaviour)

Physical needs (e.g. seating, splinting)

Other information
Are there any behaviour issues (including risk to self or others) that are relevant to this assessment?

What is the functional concern you would like Occupational Therapy to help with?

How do you feel these difficulties are affecting the child?

How concerned is the parent or carer?

What strategies / advice have already been tried to help these difficulties? (e.g. attendance at Children's centre sessions, attendance at soft play sessions, participation in fine motor activities or programmes in school etc)

Please return this referral form to:

Address: Children's OT, Green Wrythe Lane Clinic, Green Wrythe Lane, Carshalton, Surrey, SM5 1JF

Telephone: 020 8296 4140