Children's Occupational Therapy Service
Main Referral Form

Integrated Disability Service, Building 1, Saltisford Office Park, Ansell Way, Warwick, CV34 4UL Tel: 01926 413737

www.swft.nhs.uk/our-services/children-and-young-peoples-services/occupational-therapy

Sensory assessment is not commissioned as part of core Occupational Therapy services. For more information, please refer to our website or by contacting us on 02476 368848.

Referral date:		**Referral received** *office use only:*	
Child's details			
Name		**Date of birth**	
NHS Number		**Male / Female** *(please circle)*	
Parent/carer name		**Relationship to child**	
Address: **Postcode:**		**Home telephone:** **Mobile:** **Email:** **Preferred method of contact:**	
Language spoken at home?			**Is an interpreter required?**
Child:	Parent/carer:		Yes/ No
Please state any social services involvement *(please tick)***:**	CAF	Child in Need	Child Protection Plan	Child in Care
Are there any staff safety issues?			
G.P. Name		**G.P. Telephone**	
School/ nursery attended		**School tel number**	
SENCo			
Does the child have an Education, Health & Care Plan?		**Yes / no / in progress**	

Please state any other services currently involved:	
Name and profession:	**Contact number/email:**

Diagnosis (*Please attach any relevant supporting information relating to diagnosis*):

A child must be demonstrating 2 or more functional difficulties (self-care, school work, play) that are impacting significantly on his/her daily life. A request may be accepted where the child does not exhibit a cluster of functional difficulties where the local authority have a statutory duty to assess, e.g. to support a Disabled Facilities Grant application.

Which Occupational Therapy service to you want to refer to?
(please tick)

0-5 years (e.g. feeding, playing, bathing, dressing, school readiness, equipment)		**School-based functional skills (e.g. writing, scissor skills, fine motor skills 5+ years)**	
Home & School environmental (e.g. equipment/ adaptations 5-18 years)		**Upper limb / splinting service (0-18 years)**	

Please now fill in the appropriate additional information section for the service you want to refer to. If you are not sure, please contact the Duty service on 01926 742803 for further advice.

Referrer		**Profession**	
Address		**Tel No.** **Email**	
Referrer's signature			

Completed consent form attached *Without a consent form this referral will not be processed*	**Yes / no** **Verbal consent (date) -**

Warwickshire County Council

South Warwickshire NHS
NHS Foundation Trust

Additional referral information - Early Years (0 to 5 years)			
Please use this form to cover all needs of children under the age of 5 including equipment			
Child's name		**Date of birth**	
Areas of difficulty			
Sitting	(*e.g. sitting independently on the floor, sitting in a chair)*		
Does the child have any postural difficulties (e.g. hip, spine, head control, altered tone)? – *give details*			
Does the child have any feeding difficulties (e.g. dysphagia, reflux, gastrostomy)			
Getting around *please circle…*	Roll	Crawl	Walks independently
Walks with aid(s)	Uses wheelchair	Lifted/carried	Stands from sitting independently
Stands from sitting with carer assistance	Unable to stand from sitting	Hoisted for all transfers	Other
Are there any concerns around lifting/carrying for the carer? – *give details*			
Play	*e.g. picking up objects, using both hands together in play*		
Eating and drinking	*e.g. holding a cup, finger feeding, using a spoon*		
Dressing	*e.g. participating in being dressed, taking clothes off*		
Toileting	*e.g. getting on/off potty or toilet, helping with clothes*		

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Bathing	*e.g. being able to sit in bath/shower, getting in/out of bath/shower*
Bedroom	*e.g. accessing bedroom, getting in/out of bed*
Pre-school skills	*e.g. scribbling with a crayon, using scissors*
Equipment already in situ (including high street options already trialled)	

Property ownership			
Owner-occupied	**Housing association**	**Private rented**	**Local authority**
Disability Benefits	**Yes/No**	**Details**	

Are there any issues relating to safety within the home environment?.
Please give details. You may be contacted for further information on this before your referral is processed.

Additional information

Birth history

Any relevant information regarding pregnancy and birth – *give brief details*

Please return this additional information sheet with the main referral form.

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Additional referral information - School-based functional skills (5+ years)

Please complete form if

- **The child has a diagnosed physical disability and school based functional difficulties**

OR

- **The child has completed a terms worth of school based intervention on fine motor skills (please see referral criteria available on website)**

OR

- **If the child has <u>significant</u> motor coordination difficulties**

Child's name		**Date of birth**	

Evidence of completion of school based fine motor skills intervention enclosed	**Yes/ no**	If yes please attach any/all evidence of school intervention.

Areas of need *(Rate the child's difficulty with each skill)*

Self-care skills	**No difficulty**	**Mild**	**Moderate**	**Severe**	**Comments**
Dressing					
Feeding (e.g. cutlery, opening packets)					
Toileting					
Physical skills	**No difficulty**	**Mild**	**Moderate**	**Severe**	**Comments**
Ability to participate in PE					
Ability to move around school environment (e.g. tripping, bumping into things)					

Classroom skills	No difficulty	Mild	Moderate	Severe	Comments
Writing					
Pencil grasp					
Using scissors					
Following Instructions					
Organisation *e.g. Packing school bag, recording homework following timetable*					
Sitting posture					
Behaviours	**No difficulty**	**Mild**	**Moderate**	**Severe**	**Comments**
Attention / concentration					
Sitting still during a task					
Additional comments					

Please return this additional information sheet with the main referral form attached and any evidence if applicable.

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Additional referral information - Home & school environment referral (equipment/adaptations) (5 to 18 years)			
Child's name		**Date of birth**	
Home - Please complete relevant boxes			
Mobility and transfers			
Current method of getting around *e.g. carried, walks with aid, wheelchair, hoist*			
Does the child have difficulty getting in/out of the property or moving around inside the property? – *give details*			
Seating			
Does the child have any postural difficulties *e.g. hip, spine, head control, altered tone? – give details*			
Does the child have any feeding difficulties (e.g. dysphagia, reflux, gastrostomy) – *give details*			
Bathing			
Are there difficulties with bathing? (e.g. accessing the bathroom, getting in/out of bath, sitting in bath/shower) – *give details*			
Toileting			
Are there difficulties with toileting? (e.g. accessing the toilet, getting on/off toilet) – *give details*			

Sleeping
Are there difficulties with your child accessing sleeping facilities? (e.g. getting to the bedroom, getting in/out of bed) – *give details*
Are there any issues relating to safety within the home environment?. *Please give details. You may be contacted for further information on this before your referral is processed.*

Equipment currently in use	
Mobility	
Transfers	
Seating	
Bathing	
Toileting	
Bed	
Other	

Property ownership			
Owner-occupied	Housing Association	Private rented	Local authority

Benefits		
Does the child receive any disability benefits?	Yes/No	Details

School - Please complete relevant boxes		
Access to support		
No additional TA support	Access to classrooms/shared TA	1-to-1 TA
School based needs		
e.g. access to school property, moving around school, accessing toilets		
Additional information relating to referral		

Please return this additional information sheet with the main referral form.

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Additional referral information - Upper limb / splinting service (0 – 18)			
Child's name		**Date of birth**	
Reason for referral (e.g. neglect of upper limb, prevention of contractures, promoting function, reducing pain)			
Diagnosis (e.g. hemiplegic cerebral palsy, hypermobility syndrome, JIA)			
First contact with SWFT splinting service?	**Yes / no** *If yes please complete below*		
Previous splinting information			
What input from the splinting service did the child receive?			
What splint has the child had previously?			
Any other splinting services involved currently or previously?			
Is the child already known to OT? If so who?			

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Consultant information (e.g name of paediatrician / surgeon)	Physiotherapist information (if applicable)

Functional difficulties	
Using classroom equipment (e.g. pens, ruler, scissors)	*Please describe*
Using equipment at home (e.g. cutlery, hairbrush, tooth brush)	*Please describe*
If appropriate and having sought parental permission please attach a photo of the child's affected limb.	

Additional comments

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