North West London Hospitals NHS Trust

PAEDIATRIC OCCUPATIONAL THERAPY REFERRAL FORM

☎ 020 8869 2519/3010
Fax: 020 8235 4157

Paediatric Occupational Therapy Service
Children's Centre Chaucer - Level 3
The North West London Hospitals NHS Trust
Watford Road
Harrow
Middlesex HA1 3UJ

Date Received	Action	W/L		Hospital Number:

Please complete **ALL** sections and return to the Head Paediatric Occupational Therapist at the above address. Referrals will not be accepted without parental consent. Incomplete referrals will be returned.

CHILD'S DETAILS

Child's Surname: _____ Date of Birth:____/____/____

Child's First Name: _____ Boy ☐ Girl ☐

Address: _____

Full Postcode: _____ Tel.No. (home) _____ (Other)_____

Names of parents/carers:_____

Permission gained from parents/carers: YES / NO Date Obtained: ____/____/____

Family's preferred language: _____ Interpreter required YES/NO

GP name: _____

Address: _____

Telephone no:_____

Has this child previously been known to the Harrow Occupational Therapy Service? YES / NO

Is the child known to social services? YES / NO

If yes which team? _____

EDUCATIONAL DETAILS

School/ Nursery (name and address): _____

_____ Telephone No: _____

SENCO: _____ Class Teacher/ Nursery Key Worker: _____

Days attending Nursery: _____ Current Statement of Special Educational Needs? Yes/ No

MEDICAL HISTORY

Does the child have a medical diagnosis YES / NO If yes please specify _____

Significant Medical History: _____

REASON FOR REFERRAL

Please describe specific functional difficulties in areas of daily life:

Productivity e.g. play; leisure; access to the curriculum/school environment

_____

_____

Activites of daily living e.g. feeding; dressing; personal self-care.

_____

_____

Documentation e.g. prewriting; writing; keyboard skills.

_____

_____

Tool use e.g. cutlery; scissors

_____

_____

Please have the child's Class Teacher or SENCO complete the following section if referral is for school based activities (e.g.: handwriting, scissor skills etc).

Please provide evidence of strategies/ targets relating to school-based areas of difficulty and/ or attach IEP:_____

_____

Please provide a reading age assessed within the last term: _____

Does the child have specific learning difficulties (e.g.: Dyslexia): YES / NO

If yes, please give details: _____

OTHER RELEVANT INFORMATION

Please include any other relevant information: _____

_____

_____

_____*(Please attach any other relevant reports/ documents)*

Please list details of any professionals involved with the child (e.g.: Psychologist, Portage, Health Visitor, Paediatrician, Physio/Speech & Language Therapist): _____

_____

REFERRER DETAILS

Referrers Name (please write in block capitals): _____

Relationship to child: _____ Date of Referral: ____/____/____

Address: _____ Phone No: _____

Thank you for completing this form. A decision will be made as to whether or not this referral will be accepted. You will be informed of the decision in writing.
Please note if there is insufficient information/evidence this referral will not be processed and further information will be requested.