REFERRAL FORM
EALING PAEDIATRIC OCCUPATIONAL THERAPY

Putting patients at the HEART of everything we do

London North West University Healthcare NHS Trust

*Please note that this form **will not be accepted unless ALL sections are completed** – all information is important to ensure children being referred receive the most appropriate input and service – Thank you.*

SECTION A: TO BE COMPLETED BY THE REFERRER:

Name of referrer: _____ **Relationship to child:** _____

Name:	
Male/Female:	***DoB:***
Address:	***Ethnic Origin:***
	Tel No:
Postcode:	***Other Tel No:***
Language/s Spoken at Home:	***Interpreter Needed:*** Y / N (please circle)
GP:	***GP Address:***
School/Nursery:	***SENCo:***

Reason for Referral (tick as many as appropriate)

Difficulty	✓	***Your concerns in this area*** Please describe the specific difficulties your child is experiencing
Participation in Self-Care Activities Feeding		
Dressing		
Toileting		
Other		
Participation in Productive Activities (including fine motor coordination) Using different tools and items, e.g. crayons, pencils, ruler, scissors, puzzles etc.		
Participation in Play and Leisure Activities (including gross motor coordination)		

REFERRAL FORM
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Meaningful exploration and playfulness, e.g. engagement with toys or play items etc.		
Arts, crafts and hobbies		
Games and PE, e.g. accessing climbing frames, ball games etc.		

What support has been put in place to manage these difficulties at home / in school / nursery?

Other Relevant Information:

Information for Parents/Carers and Schools

(if referrer is any other professional please explain this fully to parent/carer)

By making this referral you are committing to work with and provide the necessary support to carry out the advice given and recommended by the Occupational Therapist.

Should the advice/recommendations not be carried out, the child will be discharged from the service.

Parent/Carer Consent

- ☐ I understand the reasons for this referral and **agree* / disagree* (must delete as appropriate)** to the referral.
- ☐ I **agree* / disagree* (must delete as appropriate)** to assessment information and recommendations about my child being shared with other Health, Education and Social Care Staff as required.
- ☐ I acknowledge that the information given in this referral is accurate and up to date to my knowledge.

Parent/Carer Name: _____ ***Parent/Carer Signature:*** _____

Please return to: Ealing Paediatric Occupational Therapy, Carmelita House, 21-22 The Mall, Ealing, W5 2PJ
If you have any questions please call our OT Administrator on 020 8825 8768 or contact us on LNWH-tr.EalingPaedOT@nhs.net

REFERRAL FORM
EALING PAEDIATRIC OCCUPATIONAL THERAPY

SECTION B: TO BE COMPLETED BY THE PARENT / CARER

Name of Child: ……..….. **Date of Birth: ……**

What do you hope to get from your Occupational Therapy appointment?

What are your main concerns for your child? (please tick as many as appropriate)

- ❑ **Participation in Self-Care** (Feeding, dressing, toileting)
- ❑ **Participation in Productive Activities** (Using different tools and items, e.g. crayon, pencil, ruler, scissors, puzzles, toys etc.)
- ❑ **Participation in Play and Leisure Activities** (Meaningful exploration and playfulness / Arts, crafts and hobbies / Games and PE / gross motor skill development)
- ❑ **Other**

List other concerns

Who lives in your home?

Name	***Date of Birth***	***Position in the Family***

Can you give an example of a day in the life of your child indicating what they find difficult and what they enjoy?

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Health Information:

1. Is your child taking regular medicine? Yes/No **If so what for?……**

2. Has your child ever been to hospital? Yes/No **If so what for: ……**
……...
……...

3. Previous diagnosis or care your child has received and who provided them?

Diagnosis/Care	Who provided the Diagnosis/Care

4. Does your child currently see any other health professionals? If so, please tell us who:

☐ **Speech and Language Therapy** ☐ **CDT** ☐ **Audiology**

☐ **Educational Psychology** ☐ **Physiotherapy** ☐ **Other**

Any other information you feel relevant: