|  |  |  |  |
| --- | --- | --- | --- |
| **Child`s name:** |  | | |
| **Gender / Pronouns:** |  | | |
| **Date of Birth:** |  | | |
| **NHS Number (if known):** |  | | |
| **Address:** |  | | |
| **Parent / Carer(s) Name:** |  | | |
| **Parent / Carer(s) Contact details:** |  | | |
| **Preschool/School/College:**  **Contact details:** |  | | |
| **Verbal consent for referral gained (x):** | **Yes** | | **Date:** |
| **No** | | |
| **GP Practice:** |  | | |
| **Other professionals involved (including Social care):** |  | | |
| **Are there any known safeguarding concerns?** |  | | |
| **Which Therapy team are you referring to ( please indicate with an X)** | | | |
| **Physiotherapy**  (referrals only accepted from health colleagues) | **Occupational Therapy**  (Minimum of 2 functional difficulties must be specified) | **Speech and Language Therapy** (with dysphagia or under 2 years old, otherwise refer to HCRG SLT service) | |

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|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis (if known):** | |  | | --- | |  | |  | |
| **Reason for referral:** | |
| **How is this affecting the child in their daily activities?** | |
| **What strategies/ interventions have already been tried**? (e.g. from Ordinarily Available Provision or Graduated Approach) | |
| **Referrer information** | |
| Name: |  |
| Role: |  |
| Location: |  |
| Telephone: |  |
| Email: |  |
| Signature: |  |
| Referral Date: |  |

**Please email referral to:** ruh-[tr.childrenstherapies@nhs.net](mailto:tr.childrenstherapies@nhs.net)

**Or post to:**

The Children’s Centre

Therapies Department

Zone B, Department 11

Royal United Hospital

Combe Park

Bath

BA1 3NG

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**Department Name**

Royal United Hospital

Combe Park

Bath

BA1 3NG

Tel: 01225 82xxxx

[Name.surname@nhs.net](mailto:Name.surname@nhs.net)

[www.ruh.nhs.uk](http://www.ruh.nhs.uk)