|  |  |  |  |
| --- | --- | --- | --- |
| **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 below (x):** | | | |
| **Physiotherapy** | **Occupational Therapy**  Full OT referral MUST be completed (Page3) | **Speech and Language Therapy** (with dysphagia or under 2 years old, otherwise refer to HCRG SLT service) | |

Page 1 of 2

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis (if known):** | |  | | --- | |  | |  | |
| **Reason for referral:** | |
| **How is this affecting the child in their daily activities?**  (*For Occupational Therapy Referrals please complete page 3 - the referral will not be accepted if this has not been completed.)* | |
| **What strategies/ interventions have already been tried?**  (*For re- referral for sensory challenges please attached the completed one page ‘making sense of my senses’ sensory profile which should have been completed at the end of the ‘Understanding Sensory Processing’ workshop by parents. We will not be able to accept the referral without this*) | |
| **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

**Occupational Therapy referral**

**This section should be completed with parents/ Carers input**

|  |
| --- |
| Please state 2 or more activities you would like your child to get better at |
| 1.  2.  3. |
| What specifically has already been tried to help your child with these, either at home or school/nursery? (e.g. from Ordinarily Available Provision, Graduated Approach |
|  |

**Everyday activities:**

*Does your child have any difficulties with (More than to be expected for their age): Please mark or highlight all that apply-*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Washing | Cleaning teeth | Brushing hair | Drying | Toileting | Dressing |
| Sorting/ sequencing clothes | Getting clothes the right way around | Buttons | Zips | Textures | Mealtimes |
| Using knife and fork | Being Messy | Over Fussy | Drinking from a cup | Pouring a drink |  |
| How much help do you give your child with getting dressed? | | | | | |

**School and Home Tasks:**

*Does your child have any difficulties with (More than to be expected for their age): Please mark or highlight all that apply-*

|  |  |  |  |
| --- | --- | --- | --- |
| Holding a pencil | Forming letters | Spacing | Drawing |
| Scissors skills | Using a ruler | Reading | Maths |
| Writing posture | Following Instructions | Organising themselves for school/ other tasks | Accessing the classroom or play areas |
| making friends | Socialising at play time | Concentration | PE |

**Movement & Balance skills:**

*Does your child have any difficulties with (More than to be expected for their age): Please mark or highlight all that apply-*

|  |  |  |  |
| --- | --- | --- | --- |
| Walking | Running | Jumping | Hopping |
| Standing on one leg | Kicking a ball | Balancing on apparatus | Quick changes of direction |
| Bumping into things | Tiring Easily | Throwing | Catching |
| Swimming | Riding a scooter | Riding a bike | Using Playground equipment |

**Play and Leisure**

|  |  |  |  |
| --- | --- | --- | --- |
| Describe the type of play your child enjoys: | | | |
| Indoors: | | | |
| Outdoors: | | | |
| What is your child’s favourite activity? | | | |
| Does your child participate in any sorts or extracurricular activities?  Yes: Please list:  No | | | |
| Does your child prefer to play: *(please circle/highlight)* | | | |
| Alone | With 1 or 2 friends or siblings | In a group | With older or younger children |

Any further Comments