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|  |  | |  | Care Coordination Centre  Ambley Green, Unit 5  Gillingham Business Park  Gillingham  ME8 0NJ  Tel: 0300 123 3444  Email: Medch.childrenscommunity@nhs.net |
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| **Children’s Specialist Services Occupational Therapy Referral Form** | | | |
| **Full Name of Child** |  | **DOB** |  |
| **Full Name of Parents/Carer’s** (please state relationship to the child) |  | **Address:** |  |
| **Mobile number:** |  | **Email:** |  |
| **Home number:** |  |
| **Nursery/Child Minder** |  | **Language**  (please state if an interpreter is required) |  |
| **Religion** |  | **Ethnicity** |  |
| **Name & Address Of Additional Person With Legal Parental Responsibility (If Different From Above)** | |  | |
| **GP’s Name & Address:** | |  | |
| **Referrer Details**  **Name:**  **Address:**  **Telephone Number:**  **Email Address:**  **Position: Are You The Child’s SENCO/Health Professional?**  *(Please note we do not accept parental referrals)* | |  | |
| **Please Name Other Professionals Or Services Currently Involved With Child** | |  | |
| **Current diagnoses:**  (including when any formal diagnostic assessment was carried out and by whom if known) | |  | |
| **Current Medication:** | |  | |
| **Parent/Carer Consent:** | | **Information may need to be shared with professionals in another service.**  **By ticking this box, you are confirming that the following verbal consent has been given: “I give permission for this referral to be made and to this information being shared with other agencies – including professionals from health, social care, education and Early Help Hub.”**  **Name of person giving consent (Parent or Guardian)**    **Please print name:**  **Date:** | |
| **Reason For Referral:** please state clearly what you hope the child will be able to do as a result of this clinic. | |  | |
| This child has had support from Health Visiting? YES ☐ NO ☐ | | | |
| **Please list which strategies are currently being used to support the child, including how long these have been tried.** | |  | |
| **What do you consider to be the child’s strengths?** | |  | |
| **What do you consider to be the 3 most important functional goals for this child at present?** (please be as specific as possible – e.g. to develop mark making/handwriting skills, to be able to dress independently, to be able to attend to an adult led activity, to be able to use cutlery etc.)? | | 1.  2.  3. | |
| **What strategies have you tried to address these difficulties?**  (please list including how long strategy was tried for) | |  | |
| **Relevant Social and Family History. Has the child experienced**:    A family history of neurodevelopmental disorders (such as ASD, ADHD, Dyslexia, DCD/Dyspraxia) or mental health problems (such as anxiety, depression, psychotic illness)?  ………………………………………………………………………………………………………………………………  A history of Social Care involvement with their family/safeguarding concerns?  ………………………………………………………………………………………………………………………………  Exposure to adverse childhood experiences?  ………………………………………………………………………………………………………………………………  Attachment difficulties?  ……………………………………………………………………………………………………………………………….. | | | |

Does this child have difficulties in any of the following areas? If so **please tick box and give examples of the impact on the child’s daily activities.**

|  |  |  |
| --- | --- | --- |
| **MOVEMENT SKILLS** | **Y/N** | **Comments** |
| Delayed with development, or has difficulty with,  rolling, sitting, crawling, walking |  |  |
| Has movement / co-ordination difficulties which significantly affects their ability to carry out daily  home or school activities? |  |  |
| Stamina – does the child tire quickly? |  |  |

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| **FINE MOTOR SKILLS** | **Y/N** | **Comments** |
| Manipulating, grasping and releasing objects with hands |  |  |
| Has difficulties using both hands together  during play |  |  |
| Has difficulties using pencil or crayon for Mark-making below expected range |  |  |
| **ACTIVITIES OF DAILY LIVING** | **Y/N** | **Comments** |
| Difficulties Eating/drinking and using cutlery |  |  |
| Difficulties Dressing both getting undressed and dressed |  |  |
| Difficulties Toileting including being aware of going/needing the toilet and cleaning self after. |  |  |
| Personal care activities e.g. bathing/teeth-cleaning/  hair-care |  |  |
| **SENSORY NEEDS** | **Y/N** | **Comments** |
| Tolerating or responding to sensory stimulation  e.g. touch / texture on skin / lights / movement /textures in mouth / smells / sounds |  |  |
| Seeking or avoiding movement e.g. running, spinning, climbing and jumping |  |  |
| Coping in busy environments |  |  |
| Self-stimulation / harmful behaviour to either themselves or others |  |  |
| **BEHAVIOUR** | **Y/N** | **Comments** |
| Difficulties with Attention and concentration below the expectation for developmental age |  |  |
| Difficulties with Organisation and planning skills |  |  |
| Difficulties with Anxiety / self-confidence |  |  |
| Difficulties Managing and maintaining friendships |  |  |
| Difficulties Regulating their own emotions or behaviour |  |  |
| Difficulties with communicating needs and wants. “please state if open to Speech and Language Therapy or if referral is pending.” |  |  |