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|  |   |  | Care Coordination CentreAmbley Green, Unit 5Gillingham Business ParkGillinghamME8 0NJTel: 0300 123 3444Email: 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.**

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| --- | --- | --- |
| **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.” |  |  |