

**Parent Workshop**

Preferred Location: Huntingdon Cambridge Ely Wisbech

Your name:

Name of your child: Date:

Identify your goal(s) :

1.

2.

3.

For example; being able to wash my child’s hair

being able to go to the local shop with my child

being able to support my child with dressing

**How important is this goal for you and your child? (please circle your answer)**

Low 1 2 3 4 5 6 7 8 9 10 High

**How confident do you currently feel about managing this activity? (please circle your answer)**

Low 1 2 3 4 5 6 7 8 9 10 High

**Electronic copy of this form can be sent to:** [CCS-TR.therapyreferrals@nhs.net](mailto:CCS-TR.therapyreferrals@nhs.net)