

**Children’s Occupational Therapy Referral form**

**Please complete all fields; incomplete forms will have to be returned.**

**Consent: Has informed consent been obtained for the child to be referred? Yes No**

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| **Name:** | | **Date of birth:** | | **Gender:** |
| **NHS Number:** | |  | |  |
| **Address:** | | **Postcode:** | | |
| **Telephone:** | | **Mobile:** | | |
| **Email:** | | | | |
| **Ethnicity:** | **Religion:** | **Language:** | **Interpreter needed? Yes No** | |
| **Main carer: Relationship with child:** | | | | |
| **Other carers with parental responsibility:**  **Address if different:** | | | | |
| **GP Surgery:** | | | | |
| **Does this child or the child’s family pose a risk to a lone worker:  Yes No**  **Are there any safeguarding concerns?  Yes No** | | | | |
| **Nursery  Mainstream school  Special school  Independent school  Home education**  **Name of School/Nursery: School year:**  **Is child making educational progress as expected  Yes  No**  **If no, please specify:** | | | | |
| **If applicable, indicate stage on Code of Practice:** School Action, School Action Plus, EY action, EY action plus,EHCPlan. | | | | |
| **Any medical diagnosis:** | | | | |
| **Other professionals involved:** Physiotherapist Paediatrician Social worker  Health visitor Visual Impairment Teacher or Specialist Teacher Other  Speech and Language Therapist | | | | |
| **Reason for Referral:** Please describe how the child’s difficulties are affecting their everyday life  (e.g., sitting, using the toilet, dressing, hand skills):(max 100 words) | | | | |

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| **Please indicate what universal and/or targeted support has been completed/is ongoing together with the date intervention started/ended.** (See our website for universal and targeted support)<https://www.cambscommunityservices.nhs.uk/cambridgeshire-children's-occupational-therapy>  Advice Line – Parents, Carers, Schools, other Professionals  Ready to Learn Pack (please attach)  Universal and Targeted support across all areas of daily living  Housing Information  Other  **Comments/Outcomes:** |
| **If referral for Housing Need: Please state tenancy**:  **Owner Occupier  Private rental  Social housing** please state which council or housing association  **Urgent? No  Yes  Please describe why:** |
|  |
| **Please give details of what parent/carer and child are expecting from this referral:** (max 100 words) |
| **Referrer details:**  Name:  Designation:  Email address:  Contact Address:  Telephone: |

**Once completed please send this form, together with any relevant reports or letters to:**    
[CCS-TR.therapyreferrals@nhs.net](mailto:CCS-TR.therapyreferrals@nhs.net)

**Postal address:** Occupational Therapy Admin, The Peacock Centre, Brookfield’s Hospital Campus,   
Mill Road, Cambridge CB1 3DF. **Tel:** 0300 029 5050

**PLEASE SEE OUR WEBSITE FOR UNIVERSAL AND TARGETTED SUPPORT:** <https://www.cambscommunityservices.nhs.uk/cambridgeshire-children's-occupational-therapy>