

Referral To The Paediatric Occupational Therapy Service

(When completed please return to address below)

Print Code: WQN 459 Version: 1.4

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| Name: | Referral Date: |
| Date of Birth: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| NHS Number: | Patient Ethnicity: |
| Home Tel: | Mobile Tel: |
| Address: | |
| Postcode: | |
| Date of Entry into UK: (Referral to Overseas Dept if less than 12 months) | Location of Patient: |

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|------------------------|-------------|
| Referrer: (Print Name) | Position: |
| Address: | |
| Postcode: | |
| Signature: | Tel Number: |

| | |
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| Diagnosis | |
| Relevant past medical history / surgical history / birth history / developmental history | |
| What do you want Occupational Therapy to achieve? / Preferred clinical outcome | |
| Is this child under Early Help / CIN / Safeguarding? (Please provide details) | |

| | | |
|----------------------|------|---------|
| Name: | DOB: | NHS No: |
| Location of Patient: | | |

| <p>Fine Motor Skills (for over 5yrs) (please tick)</p> <table style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Hand dominance?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Can use scissors?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Can thread beads?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Writing difficulties?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> | | Yes | No | Hand dominance? | <input type="checkbox"/> | <input type="checkbox"/> | Can use scissors? | <input type="checkbox"/> | <input type="checkbox"/> | Can thread beads? | <input type="checkbox"/> | <input type="checkbox"/> | Writing difficulties? | <input type="checkbox"/> | <input type="checkbox"/> | <p>Gross Motor Skills (for over 5yrs) (please tick)</p> <table style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Ride a bike?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Ascend / descend stairs?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Can ride scooter?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> | | Yes | No | Ride a bike? | <input type="checkbox"/> | <input type="checkbox"/> | Ascend / descend stairs? | <input type="checkbox"/> | <input type="checkbox"/> | Can ride scooter? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|----|-----------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--|--|-----|----|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hand dominance? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Can use scissors? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Can thread beads? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Writing difficulties? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ride a bike? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ascend / descend stairs? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Can ride scooter? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |

| <p>Occupational Therapy Tool Kit (please tick)</p> <table style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Has TOOL KIT been completed?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Is there a completed checklist attached?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> | | | | Yes | No | Has TOOL KIT been completed? | <input type="checkbox"/> | <input type="checkbox"/> | Is there a completed checklist attached? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--|-----|----|-------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | | | | | | | | |
| Has TOOL KIT been completed? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| Is there a completed checklist attached? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |

| <p>Self-Care Skills (for over 5yrs) (please tick)</p> <table style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Can do buttons, independent in dressing?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Can do basic self-care e.g. clean teeth, toileting?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Can use cutlery?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> | | | | Yes | No | Can do buttons, independent in dressing? | <input type="checkbox"/> | <input type="checkbox"/> | Can do basic self-care e.g. clean teeth, toileting? | <input type="checkbox"/> | <input type="checkbox"/> | Can use cutlery? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--|-----|----|--|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------|--------------------------|--------------------------|
| | Yes | No | | | | | | | | | | | | |
| Can do buttons, independent in dressing? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Can do basic self-care e.g. clean teeth, toileting? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Can use cutlery? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |

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| <p>Additional Information</p> <hr/> <hr/> <hr/> |
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| <p>Name of parent(s) or legal guardians:</p> | <p>Are the family aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>GP:</p> | <p>Consultant:</p> |

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| School / Nursery Attends: |
|---------------------------|

Please note that all boxes must be completed. Failure to do so may result in the referral being returned, which will prolong the assessment process.

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| <p>NL Children and Young People’s Team Monarch House Queensway Industrial Estate SCUNTHORPE North Lincolnshire DN16 1AL Tel : 03033 306889 Email: nlg-tr.NLChildrensTherapyTeam@nhs.net</p> | <p>NEL Children & Young People’s Team D4, Diana Princess of Wales Hospital Scartho Road GRIMSBY North East Lincolnshire DN33 2BA Tel : 03033 303758 Email: nlg-tr.GYChildrensTherapyTeam@nhs.net</p> |
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