Paediatric Occupational Therapy Referral Form

Please print and complete in black ink. **Forms lacking adequate detailed information will delay appropriate next steps for this child.** We suggest that professionals referring a child complete this form in partnership with parents/carers.If you do not have access to all the information we require please ensure you complete in as much detail as you can.

Child's Details:

First name(s):	Family name:
Date of Birth:	NHS No:
Address: Postcode:	Male / Female (please circle) Preferred telephone number: Additional telephone number:
First language:	Interpreter needed? Yes / No (please circle)

Please circle ethnic code:			
White – British	**A**	Asian/Asian British - Pakistani	**J**
White – Irish	**B**	Asian/Asian British – Bangladeshi	**K**
Any other white background	**C**	Any other Asian background	**L**
Mixed – White & Black Caribbean	**D**	Black/Black British Caribbean	**M**
Mixed – White & Black African	**E**	Black/Black British African	**N**
Mixed – White & Asian	**F**	Any other black background	**P**
Any other mixed background	**G**	Other ethnic groups – Chinese	**R**
Asian/Asian British - Indian	**H**	Any other ethnic group	**S**
		Not stated	**Z**

Any existing diagnosis?	
Any known allergies?	
Any medication?	

Child's GP:

Name of GP: Tel No:

Address of GP:

Postcode:

Details of all persons with parental responsibility:

Name:	Name:
Relationship to child:	Relationship to child:
Address: Postcode: Contact no: E-mail:	Address: Postcode: Contact no: E-mail:

Education/Childcare/Pre-school setting:

Name	**Address**	**Telephone number**	**Contact person**

When do they attend?

Does the child have an identified learning need (SEND)?

No		SEN support		Has EHCP	

Key people/agencies involved (past/present) Please attach any relevant information from these people (e.g. IEPS, reports, details of strategies or interventions), ensuring parental/carer's consent has been given.

Name	Role/Agency	Contact Details	Reason for involvement

Legal Care Status

Is the child/young person adopted? Yes / No Placing authority: Date of adoption order:	Is the child/young person looked after? Yes / No Placing authority: Interim care order / care order / section 20 / placement order / other: Were the foster carers approved by Solihull? Yes / No If no, by whom?:
Allocated social worker:	Social work team:
Email & contact number:	Foster carers' link worker & contact number:
Is this child on a child protection plan? Yes / No	Is this child entitled to NHS treatment? Yes / No

Consent for this referral *(Informed consent from a parent or legal guardian must be obtained before submitting the referral):*

I/We give consent for a referral for assessment to be made for the above named child to the service(s) indicated above.

Signed:

Relationship to child: **Date:**

Referrer details:

Name:	**Address:**
Designation:	**Contact no:** **E-mail address:**
Referrers signature:	

Reason for referral

Paediatric Occupational Therapy (OT) consider a child's occupational performance in activities of daily living (their "occupations"), including self-care (like dressing, toileting or teeth brushing), school (such as handwriting, using a ruler or using scissors) and leisure activities (including riding a bike or using skipping ropes), that are age and developmentally appropriate. In order to be accepted to the service:

- Children/young people referred are aged between 0-18 years registered with a Solihull GP.
- There is clear evidence of a difficulty in the performance of occupations that is not age or developmentally appropriate.

NB: if the young person requires specialist equipment/adaptation *at home* they should be referred directly to the Solihull Social Care team.

Self-care: *What difficulties are encountered when engaging in self care activities e.g. problems in bathing, putting on make up, toileting, eating, hygiene or achieving independence in daily routines, where this is not age or developmentally appropriate?*	
Productivity (including school/nursery/voluntary work/work experience): *What difficulties are encountered when engaging in productive activities e.g. joining in sports/P.E., accessing the environment, handwriting, using classroom equipment, use of AAC, doing household chores, where this is not age or developmentally appropriate?*	
Leisure: *What are the difficulties encountered when engaging in leisure activities, e.g. operating toys, outdoor play, how does the child spend their free time, accessing a range of play activities, what help do they need to engage in these, where this is not age or developmentally appropriate?*	
What strategies have been trialled already and with what result?	
What would caregivers like to achieve through Occupational Therapy support?	

Additional information:					
Does this child have an acute/life-limiting/deteriorating condition?			**Yes** ☐	**No** ☐	
Are there seating concerns for the child/young person at home or school			**Yes** ☐	**No** ☐	
Are there any issues visiting the child at home? If yes, in what way?			**Yes** ☐	**No** ☐	
Has the child been known to Occupational Therapy previously? If yes, when?			**Yes** ☐	**No** ☐	
Academic levels (if known)		**Date of assessment:**			
Maths:					
Reading					
Spelling:					
Outcome of most recent vision and hearing tests		**Date of assessment:**			
Vision:					
Hearing:					

Please return this form, along with the Electronic Patient Record and Sharing of Information form (signed by parents/carers) via post to:

Paediatric Occupational Therapy
1st Floor, Chelmsley Wood Primary Care Centre
Crabtree Drive
Birmingham
B37 5BU

If you require this referral form in any other format, such as large print, or if you need help to complete this, please contact the department on **0121 722 8010**.

Your Electronic Patient Record and the Sharing of Information

Please read this leaflet carefully. It will give you information about the sharing of your electronic patient record and the choices you need to make.

Today, electronic records are kept in all the places where you received healthcare. These NHS Care Services (and services who provide care on behalf of the NHS) can usually only share information from your records by letter, email, fax of phone. At times, this can slow down your treatment and mean information is hard to access.

Solihull Community NHS Services use a computer system called SystmOne to electronically record an individuals health information. SystmOne allows this information to be shared with other health organisations using SystmOne. For Solihull Community Health Services this includes GPs and Marie Curie Hospice.

We are telling you about this because you have the choice in deciding if your information is shared with other Health Professionals involved in your care.

This form is asking for your preference in sharing your electronic Community Health Services record. You can choose to share or not share this information with other SystmOne organisations.

NB. Please note that this form is not about your Summary Care Record (sometimes abbreviated to SCR). This is medical information about you that is stored centrally to be used in an urgent or emergency situation.

Benefits of sharing your health care record

Patient care can be supported by healthcare staff having faster access to your medical information and you may not be required to repeat information to different NHS staff treating you, for example healthcare staff who are involved in your care will be able to access your medical history immediately, enabling them to assess the provision of your care better.

How is my decision recorded?

Our computer system has two settings to allow you to control how your medical information is shared.

Sharing Preference for: PAEDIATRIC OCCUPATIONAL THERAPY, SOLIHULL COMMUNITY SERVICES

Sharing Out

This controls whether your full electronic patient record can be shared with other SystmOne Organisations where you are treated. Please tick to record your preference.

- ☐ Yes (shared) OR
- ☐ No (not shared)

Sharing In

This controls whether we can view information recorded by other SystmOne Organisations where you have received treatment. Please tick to record your preference.

- ☐ Yes (shared) OR
- ☐ No (not shared

Patient's name:
Patients date of birth:
If not the patient, your relationship to them:
Patient/Representative signature: Date: