

## 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 you ensure you complete in as much detail as you can.

### Child's Details

|                                   |  |                                   |          |
|-----------------------------------|--|-----------------------------------|----------|
| Child's first name/s:             | Child's Family name:                         |                                   |          |
| Date of Birth:                    | NHS No:                                      |                                   |          |
| Address:                          | Male / Female (please circle)                |                                   |          |
|                                   | Telephone No:                                |                                   |          |
| Postcode:                         | Mobile:                                      |                                   |          |
| First Language:                   | Interpreter needed? Yes / No (please circle) |                                   |          |
| <b>Please circle ethnic code:</b> |  | Asian/Asian British- Pakistani    | <b>J</b> |
| White - British                   | <b>A</b>                                     | Asian/Asian British – Bangladeshi | <b>K</b> |
| White - Irish                     | <b>B</b>                                     | Any Other Asian Background        | <b>L</b> |
| Any Other White Background        | <b>C</b>                                     | Black/Black British Caribbean     | <b>M</b> |
| Mixed - White & Black Caribbean   | <b>D</b>                                     | Black/Black British African       | <b>N</b> |
| Mixed – White & Black African     | <b>E</b>                                     | Any other Black Background        | <b>P</b> |
| Mixed – White & Asian             | <b>F</b>                                     | Other Ethnic Groups – Chinese     | <b>R</b> |
| Any Other Mixed Background        | <b>G</b>                                     | Other Any Other Ethnic Group      | <b>S</b> |
| Asian/Asian British- Indian       | <b>H</b>                                     | Not Stated                        | <b>Z</b> |

**Any existing diagnosis?**

**Any known allergies?**

**Any medication?**

### Child's G.P

|                |         |
|----------------|---------|
| Name of GP:    | Tel No: |
| Address of GP: |         |
| Post code :    |         |

### Details of all persons with Parental Responsibility

|                        |                        |
|------------------------|------------------------|
| Name:                  | Name:                  |
| Relationship to child: | Relationship to child: |
| Address:               | Address:               |
| Postcode:              | Postcode:              |
| Contact No:            | Contact No:            |
| Mobile No:             | Mobile No:             |

Any issues with home visits?

### Educational/Childcare/Pre-School Setting:

| Name | Address | Telephone Number | Contact Person |
|------|---------|------------------|----------------|
|      |         |                  |                |

When do they attend?

Is this child on the Special Educational Needs & Disability (SEND) Code of Practice?

|    |  |             |  |                                     |  |
|----|--|-------------|--|-------------------------------------|--|
| No |  | SEN Support |  | Has an EHC Plan or Statement of SEN |  |
|----|--|-------------|--|-------------------------------------|--|

**Key people/agencies involved (past or present)** Please attach any relevant information from these people (e.g. Playplans/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**

|  |  |
|--|--|
| <p>Is the child/young person adopted?<br/>Yes* / No</p> <p>Placing authority:</p> <p>Date of Adoption Order:</p> | <p>Is the child/young person looked after?<br/>Yes / No</p> <p>Placing authority:<br/>Interim Care Order / Care Order / Section 20 /<br/>Placement Order / Other:</p> <p>Were the Foster Carers approved by Solihull?<br/>Yes / No<br/>If no, by whom?</p> |
| <p>Allocated Social Worker</p>   | <p>Social Work Team</p>  |
| <p>Email &amp; contact number</p>  | <p>Foster Carers' Link Worker &amp; Contact Number</p>   |

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 in this section must be obtained before submitting a request for a 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:** \_\_\_\_\_

|                          |                        |
|--------------------------|------------------------|
| <b>Referrer Details:</b> |                        |
| <b>Name:</b>             | <b>Address:</b>        |
| <b>Designation:</b>      | <b>Contact Number:</b> |

**Referrers Signature:**

**Referral Details**

Paediatric Occupational Therapists support the occupational performance of young people with motor, process or sensory difficulties that affect their participation in everyday activities at home, at school and/or at play who meet the following criteria:

- Children/young people aged between 0-18 years registered with a Solihull GP.
- There is clear evidence of a difficulty in the performance of everyday activities as a result of motor, process or sensory difficulties
- OR the young person is limited in their ability to achieve social/developmental/educational goals as a result of environmental constraints (NB: if the young person requires specialist equipment/adaptation at home they should be referred directly to the Solihull Social Care team)

Reason for referral:

**Performance area/s of concern**

Self-care skills

School/nursery

Play/leisure

**Additional information**

Does this child have an acute/life-limiting/deteriorating condition? **Yes**  **No**

Is there a malfunction/breakdown of essential equipment putting the child/carer at risk? **Yes**  **No**

Are there any issues re: visiting the child at home? **Yes**  **No**

If yes then please state.....  
.....

**Sensory Processing**

Please indicate here if you have particular concerns that sensory processing issues may be impacting on the young person's performance of everyday activities

Please indicate here if parents/carers have **already completed** a Sensory Profile (**please attach a copy of the completed form** to this referral)

**For referrals made by colleagues in education** – please provide additional information on the reverse of this form.

**Parent/carer and nursery/school/college questionnaires** – please note that referrals will not be accepted unless parent/carer and school questionnaires are returned with the referral form. Alternative questionnaires for pre-school children and young people with complex learning/health needs are available from the occupational therapy team on request – please call for additional information.

Please enclose any copies of reports/ correspondence that may help describe the child's strengths and difficulties and return this form, along with the Electronic Patient Record and Sharing of Information form (signed by parents/carers) to:

**Paediatric Occupational Therapy**  
**1<sup>st</sup> Floor, Chelmsley Wood Primary Care Centre**  
**Crabtree Drive**  
**Birmingham**  
**B37 5BU**

**Tel: 0121 722 8010**

## For referrals made by colleagues in education

In many cases some simple strategies can make a difference to a child's performance at school. **Please indicate which strategies you have tried before making a referral to the occupational therapy team** and estimate how long the strategy has been in effect in terms of days or weeks. You are also invited to comment on the success of these strategies. In some cases a referral will not be accepted by the occupational therapy team until it can be demonstrated that strategies have already been tried.

| Strategy  | Duration of trial | Success/comments |
|---|-------------------|------------------|
| Desk and chair are the correct height i.e. feet flat, desk at elbow height                                |                   |                  |
| New seating position in class e.g. near the front, facing the board                                       |                   |                  |
| Use of a sloping writing surface  |                   |                  |
| Alternative writing tools e.g. Stabilo pen, triangular pencil, Yoro pen, wider lines on paper             |                   |                  |
| Reduce amount of writing e.g. scribe, handouts with key-words missing                                     |                   |                  |
| Give more time to complete task   |                   |                  |
| Secure the paper to the desk e.g. with Dycem or bluetac   |                   |                  |
| Verbal and visual reminders of task information e.g. post-it notes, highlighted instructions on the board |                   |                  |
| Provide "movement breaks"   |                   |                  |

| P.E.   |  |  |
|--|--|--|
| Allow extra time to change for PE e.g. send to changing room first |  |  |
| Pair with a buddy to help get changed                              |  |  |
| Provide alternative equipment e.g. larger balls, bigger bat        |  |  |

| Motor skills programme       |  |  |
|------------------------------|--|--|
| Motor skills group e.g. BEAM |  |  |

| Homework  |  |  |
|---|--|--|
| Give out at the start of the lesson                               |  |  |
| Designate a "homework buddy" that the child can call after school |  |  |

## Occupational Therapy Referral Teacher Questionnaire

To help with our assessment this questionnaire should be completed and returned to the Occupational Therapy Department along with the referral form. **Please note:** this referral will not be accepted unless questionnaires completed by parents/carers and school are returned.

| Child's Details       |                      |
|-----------------------|----------------------|
| Child's first name/s: | Child's Family name: |
| Date of Birth:        | NHS No:              |

|                 |               |
|-----------------|---------------|
| Date completed: | Completed by: |
|-----------------|---------------|

| Formal evaluations e.g. Cognitive tests |
|---|
| Name of test:                           |
| Date given:                             |
| Full Score:                             |
| Component scores:                       |

| Academic levels | Date of assessment |
|-----------------|--------------------|
| Reading         |                    |
| Spelling        |                    |
| Maths           |                    |

| Other pertinent evaluations | Date of assessment | Outcome |
|-----------------------------|--------------------|---------|
|                             |                    |         |

|  |  |
|--|--|
| <b>When is the child due to change school?</b> |  |
| <b>What level of SEN support is provided?</b>  |  |

**Please tick the statements that are pertinent to this child.**

*Gross motor*

- Seems weaker than other children his/her age
- Does not have the endurance other children his/her age have for an activity
- Difficulty with hopping, jumping, skipping or running compared to others his/her age
- Appears stiff and awkward in his/her movements
- Clumsy, does not appear to know how body works, bumps into others or objects, never quite sits in chair correctly
- Does not seem to understand concepts such as right, left, front or back as it relates to his/her body
- Shies away from playground equipment. May only play on one particular item
- Poor posture (always seems to be leaning against something, shoulders slump forward)
- Has difficulty with transitions between activities and locations
- Requires adaptation of the physical environment to access educational opportunities (e.g. seating, positioning, modified PE equipment etc)

*Fine Motor*

- Difficulty with drawing, colouring, tracing
- Performs these activities quickly and result is usually sloppy
- Avoids fine motor activities
- Problem holding pencil, grasp may be very loose or very tight
- Printing is too dark, too light, too large, too small
- Does not seem to have a dominant hand
- Has difficulty manipulating school tools such as ruler, paintbrush, compass
- Has difficulty or is unable to produce hand-written work

*Academic*

- Distractible
- Restless
- Slow worker
- Disorganised, messy desk
- Short attention span
- Hyperactive
- Can't follow directions
- Never completes assignments

*Sensory processing*

- Withdraws from touch
- Touches everything
- Avoids being close to others
- Fearful of being off the ground
- Doesn't like playground equipment such as slide, swing
- Can't seem to stop moving, craves swinging, rocking
- Trouble discriminating shapes, letters or numbers
- Cannot complete puzzles appropriate for age
- Difficulty copying designs, letters or numbers
- Difficulty tracking (eg reading or following teacher's arm movements)

*Emotional and behavioural responses*

- Does not like to have routine changed
- Is easily frustrated
- Cannot get along with others
- Accident prone
- Copes better 1:1 or in a small group

*Personal care*

- Needs assistance with toileting
- Needs assistance or extra supervision with meals/drinks/snacks

- Please attach a typical example of the child's writing or a drawing and their most recent IEP.

|                       |  |
|-----------------------|--|
| <b>Current school</b> |  |
| <b>Teacher</b>        |  |
| <b>Senco</b>          |  |
| <b>Date:</b>          |  |

**Please return form to:**

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

## Occupational Therapy Referral Parent/Carer Questionnaire

To help with our assessment this questionnaire should be completed and returned to the Occupational Therapy Department along with the referral form. **Please note:** this referral will not be accepted unless questionnaires completed by parents/carers and school are returned.

| Child's Details       |                      |
|-----------------------|----------------------|
| Child's first name/s: | Child's Family name: |
| Date of Birth:        | NHS No:              |

|                 |               |
|-----------------|---------------|
| Date completed: | Completed by: |
|-----------------|---------------|

| Family details                 |             |
|--------------------------------|-------------|
| Mum's name:                    | Dad's name: |
| Siblings:                      |             |
| With whom does the child live? |             |

|   |
|---|
| If you <b>do not</b> wish us to contact the school/nursery please tick here: <input type="checkbox"/> |
|---|

Listed below are some of the areas in which an occupational therapist may be able to help a child. Please tick the areas that your child finds difficult and comment if appropriate.

| Activities of daily living                   | Additional Comments |
|--|---------------------|
| <input type="checkbox"/> Dressing            |                     |
| <input type="checkbox"/> Eating and drinking |                     |
| <input type="checkbox"/> Toileting           |                     |
| <input type="checkbox"/> Washing/bathing     |                     |
| <input type="checkbox"/> Seating at home     |                     |

| Parental Concerns School/Nursery                  | Additional Comments |
|---|---------------------|
| <input type="checkbox"/> Using a pencil/writing   |                     |
| <input type="checkbox"/> Using computer equipment |                     |
| <input type="checkbox"/> Concentration/attention  |                     |
| <input type="checkbox"/> Following instructions   |                     |
| <input type="checkbox"/> Moving around the school |                     |
| <input type="checkbox"/> Organisation             |                     |

| Play/leisure  | Additional Comments |
|---|---------------------|
| <input type="checkbox"/> Avoids activities such as Lego, jigsaws              |                     |
| <input type="checkbox"/> Dislikes playground equipment e.g. slide, roundabout |                     |
| <input type="checkbox"/> Prefers sedentary/quiet play                         |                     |
| <input type="checkbox"/> Always seems very active                             |                     |
| <input type="checkbox"/> Has difficulty accessing leisure opportunities       |                     |

Please comment on any other concerns that you have about your child in the space below:

Thank you!

**Please return form to:**

Paediatric Occupational Therapy

1<sup>st</sup> Floor, Chelmsley Wood Primary Care Centre, Crabtree Drive, Birmingham, B37 5BU

## 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 or 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 individual's 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: .....

Patient date of birth: .....

If not the patient, your relationship to them: .....

Patient/Representative signature: ..... Date: .....