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| **Children’s Occupational Therapy Motor Skills Service Referral Form** |
| **Please ensure you have read the Motor Skills Service Information before completing this referral to ensure Occupational Therapy is the right service to help this child.** |

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| **PATIENT INFORMATION** | |
| Name:  Date of Birth:  Male / Female:  NHS No (if known):  Address:  Post Code:  Tel / Mobile No:  Name of Parents / Carers:  Email:  Who has parental responsibility, if not as above? | GP Surgery: |
| School / nursery attended: |
| Preferred Language:  Interpreter required? |
| Diagnosis? (if any): |
| Is this a Looked After Child (LAC) Yes/ No  Is this child under a care plan? Yes/ No  Identified risks? Yes/ No  Consent for referral? |
| Does the child have an EHCP? EHCP in progress? | |
| Are there other professionals involved with this child? If yes please give names below  🞏 Consultant 🞏 Educational Psychologist  🞏 Physiotherapist 🞏 Social Worker  🞏 Speech & Language therapist 🞏 Others | |
| Were there any complications during pregnancy / the new-born period?  At what age did your child achieve his / her motor milestones?   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Sitting: |  | Crawling: |  | Walking: |  | Talking: |  |   Relevant medical history & development: **(continue on page 3 if necessary)** | |
| **REFERRER’S DETAILS** | |
| Name: Designation: Email: | |
| Address: Contact Telephone No: | |
| Referrer’s Signature: Date of referral: | |

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| **REASONS FOR REFERRAL** | |
| **What are the concerns you would like Occupational Therapy to help with?**  **Please give examples of WHO is concerned and HOW the problems make it harder or stop the child doing something they want or need to do e.g. How does it affect the child’s daily life?** | |
| **Please tell us about any relevant advice that has been given already.**  **Tell us about anything that family or school have already tried to help and for how long.** | |
| **Has this child had previous OT input from anywhere?** (NHS or private)  **If yes, please tell us about it or attach any reports.** | |
| In your estimation, how is this child performing with their learning?   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Above average |  | Average |  | Slightly below average |  | Significantly below average |  |   Does this child have known reading or writing difficulties? YES NO  **If yes, please describe:**  Slight delay. | |
| Does the child receive any additional support in nursery / school? | |
| Please write any other comments or information you think may be helpful. | |
| **Please return the form by email to** [**seftoncommunity.physio-ot@nhs.net**](mailto:seftoncommunity.physio-ot@nhs.net) | |
| **North Sefton** Children’s Occupational Therapy Service  Ainsdale Centre for Health and Wellbeing  164 Sandbrook Road  Ainsdale, Southport, PR8 3RW  **Tel:** 01704 395895  Referral postcodes: PR8, PR9, L37 | **South Sefton** Children’s Occupational Therapy Service  Sefton Carers Centre  27-37 South Road  Waterloo L22 5PE  **Tel:** 0151 252 5836  L20, L21, L22, L23, L30, L31, L38 & Sefton parts of L10 |
| **Please ensure you have completed all sections of the form fully to avoid delay and to assist us in prioritising the child’s needs – incomplete forms will be returned. Please ensure this referral has been discussed with parent / carer and consent to referral gained.** **Thank you.**  **If you notice a significant deterioration in this child’s functional or physical ability please contact the child’s GP and the Occupational Therapy service directly.** | |