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| **Children’s Occupational Therapy** **Sensory Workshop Parent/Carer Referral Form** |
| **Please ensure you have read the Sensory Processing Information Leaflet before completing this form. This should have been given to you with this referral form.** |

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| **CHILD’S INFORMATION** |
| Name: Address:Post Code: Date of Birth:Tel / Mobile No: Gender: NHS No (if known):  | GP Name:Address: |
| Consultant:Hospital: |
| Name of Nursery / School attending: |
| Ethnicity:Faith: | Name of Parents/Carers: |
| Diagnosis (if any): |
| Relevant Medical History & Development: |
| Other professionals involved: |
| Is this a Looked After Child (LAC) | Yes No  |
| Is this child subject to:* A Child Protection Plan
* A Child in Need Plan
* Team Around the Family meetings (TAF)
 | Yes No Yes No Yes No |
| **PARENT/CARER DETAILS** |
| Name: Relationship to Child: |
| Address: |
| Contact Telephone No: Email: |
|  Signature: Date:  |
| Please state which professional provided this referral form:  |
| **Children’s Occupational Therapy** **Sensory Workshop Parent/Carer Referral Form** |

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| Child’s Name: DOB:   |

**Please answer the following statements in relation to your child, ensuring you have completed all sections – incomplete referral forms will be returned:**

|  |  |  |  |  |  |
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| **TACTILE (TOUCH) SENSE** | Y | N |  | Y | N |
| Reacts negatively to touch |  |  | Sensitive to clothing textures/labels etc |  |  |
| Avoids getting messy |  |  | Has difficulty standing close to others |  |  |
| Expresses distress during bathing/grooming |  |  | Constantly touching people or objects |  |  |
| Please give examples of how the above affects your child’s day to day functioning: |
| **AUDITORY (SOUND) SENSE** | Y | N |  | Y | N |
| Responds negatively to a variety of loud or unexpected noises |  |  | Misses name being called / needs instructions repeating a lot |  |  |
| Holds hands over ears for protection |  |  | Significantly distracted by noises |  |  |
| Cannot tolerate loud environments |  |  | Makes noise for noise sake  |  |  |
| Please give examples of how the above affects your child’s day to day functioning: |
| **VISUAL (SIGHT) SENSE** | Y | N |  | Y | N |
| Expresses discomfort or avoids bright lights |  |  | Bothered by lights after others have adapted |  |  |
| Covers eyes or squints a lot |  |  | Significantly distracted by lights or visuals |  |  |
| Prefers to be in darker environments |  |  | Seeks out objects that light up or spin  |  |  |
| Please give examples of how the above affects your child’s day to day functioning: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TASTE / TEXTURE / SMELL SENSES** | Y | N |  | Y | N |
| Gags easily with food textures or utensils |  |  | Significantly avoids or seeks out smells |  |  |
| Significantly avoids or seeks out typical tastes |  |  | Unaware of drooling or food on face |  |  |
| Significantly avoids or seeks out textures |  |  | Chews or licks on non-edible items |  |  |
| Please give examples of how the above affects your child’s day to day functioning: |
| **VESTIBULAR (MOVEMENT) SENSE** | Y | N |  | Y | N |
| Seeks all kind of movement e.g. can’t sit still |  |  | Rocks unconsciously when sitting or standing |  |  |
| Spins self frequently throughout the day |  |  | Becomes anxious when feet leave the floor |  |  |
| Enjoys feel of falling or hanging upside down  |  |  | Becomes overly excited during movement |  |  |
| Please give examples of how the above affects your child’s day to day functioning: |
| **PROPRIOCEPTION (BODY AWARENESS)**  | Y | N |  | Y | N |
| Bounces & crashes on furniture or floor |  |  | Constantly bumps into objects or people  |  |  |
| Seeks out tight hugs and squeezes |  |  | Frequent toe walker |  |  |
| Wraps in blankets / seeks out tight spaces |  |  | Constantly chewing on non-edible items |  |  |
| Please give examples of how the above affects your child’s day to day functioning: |
| **What strategies have already been tried?** |
| **Please return the form to:** seftoncommunity.physio-ot@nhs.net or |
| **North Sefton** Children’s Occupational Therapy ServiceAinsdale Centre for Health and Wellbeing164 Sandbrook RoadAinsdale, Southport, PR8 3RJ**Tel:** 01704 395895 Referral postcodes: PR8, PR9, L37 | **South Sefton** Children’s Occupational Therapy ServiceSefton Carers Centre27-37 South RoadWaterloo L22 5PE**Tel**: 0151 252 5836L20, L21, L22, L23, L30, L31, L38 & Sefton parts of L10 |