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| **Sefton Community Physiotherapy & Occupational Therapy Service Referral Form** |
| **Which service/s are you referring to:  Physiotherapy  Occupational Therapy**  **Please ensure you have read the service leaflet prior to completing this referral form. Please note that therapy intervention will only be effective if someone is able to carry out the recommendations and advice in everyday activities both at home and in educational settings.** |

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| **PATIENT INFORMATION** | |
| Name:  Address:  Postcode  Date of Birth:  NHS No (if known):  Tel / Mobile No:  Birth Gender:  Ethnicity / Faith:  Name of Parents / Carers:  Who has parental responsibility, if not as above?    Parent Email: | GP Surgery: |
| School / Nursery (if attending): |
| 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  Parental consent for referral? Yes  No |
| Does the child have an EHCP? Yes  No  or is an EHCP / Needs Assessment in progress? Yes  No | |
| Are there other professionals involved with this child? If yes, please give contact details below:  Consultant  Educational Psychologist/Portage  Occupational Therapist  Social Worker  Physiotherapist  Orthotics  Speech & Language Therapist  Others  Contact Details: | |
| **REFERRER’S DETAILS** | |
| Name: Designation: | |
| Address: | |
| Email: Contact Number: | |
| Referrer’s Signature: Date of referral: | |

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| **PATIENT HISTORY** |
| **Birth History & General Development** (if premature, what was the estimated delivery date?):  At what age did your child achieve their motor milestones?   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Rolling: |  | Sitting: |  | Crawling: |  | Walking: |  | Talking: |  |   Other Medical History / Medications:  Investigations / results: e.g. x-ray / CT scan etc. |
| **Please tell us about any relevant advice that has been given already.**  Tell us about anything that family or school/nursery have already tried to help and for how long e.g. school-based motor groups, previous exercises, activities or advice sheets given. |
| **Has this child had previous Physiotherapy or Occupational Therapy input from anywhere?** **If so, is this current referral for new concerns where input and advice has not already been provided?**  Please tell us about any previous input or attach any reports. |
| **In your estimation, how is this child performing with their learning / cognitive development?**  Above average  Average  Slightly below average  Significantly below average |
| **Does the child receive any additional support in nursery / school?** |
| **What do you hope the child / young person will gain from this referral?** |

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| **REASONS FOR REFERRAL** |
| **What are the concerns you would like Physiotherapy and/ or Occupational Therapy to help with?**  Please give examples of who is concerned and the impact of these concerns on the child’s function in everyday life both at home and in school/nursery.  Please complete only the areas where you have the main concern – you **DO NOT** need to complete all the sections if not relevant to this current referral. |
| **Gross Motor Development / Functional skills impacting physical activity and exercise:** |
| **Fine Motor Development / Classroom Skills e.g. pencil, handwriting & scissor skills:** |
| **Self-care and Independence Skills e.g. dressing, bathing, cutlery use:** |
| **Postural Care / Moving & Handling:** |

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| **Please detail any other information you think may be helpful:** |

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| **Please return the form by email to** [**seftoncommunity.physio-ot@nhs.net**](mailto:seftoncommunity.physio-ot@nhs.net) | |
| **North Sefton** Children’s Community Physiotherapy & Occupational Therapy Service  Ainsdale Centre for Health and Wellbeing  164 Sandbrook Road  Ainsdale, Southport, PR8 3RJ  Tel:0151 282 4846  Referral postcodes: PR8, PR9, L37 | **South Sefton** Children’s Community Physiotherapy & Occupational Therapy Service  Blossom House (Alder Park)  Park Road  Waterloo L22 3XE  Tel: 0151 252 5729 / 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.**  **If you notice a significant deterioration in this child’s functional or physical ability, please seek immediate medical advice.** | |