|  |
| --- |
| **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.** |

|  |  |  |
| --- | --- | --- |
| **CHILD’S INFORMATION** | | |
| Name:  Address:  Post Code:  Date of Birth:  Tel / Mobile No:  Parent Email:  Gender:  NHS No (if known): | GP Name: | |
| Name of Nursery / School attending: | |
| Name of Parents/Carers: | |
| Who has parental responsibility, if not as above? | |
| Parental consent for referral? Yes/No | |
| Preferred Language if not English: | |
| Ethnicity: |
| 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 |
| **REFERRER DETAILS** | | |
| Name: Relationship to Child: | | |
| Address: | | |
| Contact Telephone No: Email: | | |
| Signature: Date: | | |
| If parent referral, please state which professional provided this referral form: | | |
| **Children’s Occupational Therapy**  **Sensory Workshop Parent/Carer Referral Form** | | |

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

**Child’s Name: DOB:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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](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 3RJ  **Tel:** 0151 282 4969  Referral postcodes: PR8, PR9, L37 | | | **South Sefton** Children’s Occupational Therapy Service  Blossom House (Alder Park)  Park Road  Waterloo L22 3XE  **Tel:** 0151 282 4969  L20, L21, L22, L23, L30, L31, L38 & Sefton parts of L10 | | | |