**Guidelines for making referrals to School Based Occupational Therapy**

**School aged children with functional difficulties (aged 5-18)**

**The Referral Process:**

* We operate an open referral system. This means that we accept referrals from anybody; however this must be with the agreement of parents/carers.
* Ideally school referrals should be made via the SENCO.
* Parents wishing to refer their children directly may do so by telephoning the department on Halifax 01422 261340, and Huddersfield 01484 344299.
* Children of any age may be referred.

**What you need to do:**

* You must complete the referral form and the attached questionnaire. Please include as much information as you can, including the child’s attainment levels.
* If we do not receive this additional information, it will result in the referral not being accepted.
* You must obtain **written parental/caregiver consent** (a signature) in order to refer to our service. The referral form has a section for this.



COMMUNITIES DIVISION

Therapies Directorate

Children’s Therapy Services

AGE 5-18 REFERRAL FORM

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** | | Referrer Name, Address & Designation:    Tel No: E-mail: | | | Date: |
| **Name of parent/person with parental responsibility:** | |
| Address: | |
| NHS No: | | DOB: | Gender: |
| Home Telephone No: | Mobile No: | | | Work No: | |
| e-mail address: | | | Preferred method of contact :  *Mail*  *Home No*  *Work No*  *Mobile No*  *E-mail* | | |
| GP Name & Practice: | | | First language spoken by child:  First language spoken by parents:  Is interpreter needed? Yes  No  Religion: | | |
| Medical condition if known: | | | | | |
| School/Nursery/Playgroup attended: | | | | | |
| Any other agencies involved:  *If yes please give contact names and brief details:* | | | | | |
| Educational support *(please attach latest IEP*):  None:  Additional support in school/setting:  Statement or EHC:  Unknown: | | | | | |

**WHICH CHILDREN’S SERVICE IS REQUIRED?**

*Please submit separate forms if more than 1 service is required*

Children’s Occupational Therapy:  Children’s Physiotherapy:  Children’s Speech & Language Therapy:

|  |
| --- |
| **REASON FOR REFERRAL** (*Please give as much information as possible including the results of tests and investigations)* |

Name of Parent/Guardian:

Consent from Parent/Guardian (Signature)

Consent to share information with other health care or education professionals; these will be discussed with you Yes  No

Is there any other relevant information that we should be aware of?

*Please tick one*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| British or mixed British |  | White & Asian |  | Other Asian background |  | Black British |  |
| Irish |  | Other mixed Background |  | Caribbean |  | Other Black or Black  unspecified |  |
| Other White background |  | Indian or British Indian |  | African |  |
| White & Black Caribbean |  | Pakistani or British Pakistani |  | Other black background |  |  |  |
| White & Black African |  | Bangladeshi or British Bangladeshi |  | Chinese |  |  |  |

**Please return to: Children’s Therapy Services, Princess Royal Health Centre, Greenhead Road, Huddersfield, HD1 4EW**

**Tel: 01484 344299 email: cah-tr.childrenstherapy@nhs.net**

**OR**

**Children’s Therapy Services, Broad Street Plaza, Halifax, HX1 1UB**

**Tel: 01422 261340**

**CHILDREN’S OCCUPATIONAL THERAPY SERVICE**

**REFERRAL QUESTIONNAIRE FOR SCHOOL AGED**

REFERRAL QUESTIONNAIRE

Date

Child’s Name DOB

School Teacher

Statement/EHC Yes / No

School Action Yes / No

School Action Plus Yes / No

In order for us to process and respond to this referral, you need to give us as much detailed information about the child as possible.

\* Please include a copy of the child’s latest Support Plan with this referral form.

Does the child have any known condition/diagnosis? please name:

Does the child have a learning difficulty?

**Please describe your main concerns for the child/young person in the relevant areas below:**

* Activities of daily living (e.g. washing, dressing, toileting, eating)
* Gross and fine motor co-ordination skills (e.g. handwriting, scissor skills, cutlery skills, moving around the environment, throwing/catching, balancing)
* Concentration/organisation

**Please give details of child’s learning ability:**

*(School referrals - please provide details of child’s learning profile)*

**What strategies have been tried/are in place at present?**

**Please give details as to why strategies used have not worked and/or what additional support you now require?**

**What are the child’s goals (I.e. what would they like to be able to do/be better at)?**

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