

**Children’s Occupational Therapy Referral form**

**Please complete all fields; incomplete forms will have to be returned.**

**Consent: Has informed consent been obtained for the child to be referred? Yes No**

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| --- | --- | --- | --- | --- |
| **Name:** | | **Date of birth:** | | **Gender:** |
| **NHS Number:** | |  | |  |
| **Address:** | | **Postcode:** | | |
| **Telephone:** | | **Mobile:** | | |
| **Email:** | | | | |
| **Ethnicity:** | **Religion:** | **Language:** | **Interpreter needed? Yes No** | |
| **Main carer: Relationship with child:** | | | | |
| **Other carers with parental responsibility:**  **Address if different:** | | | | |
| **GP Surgery:** | | | | |
| **Does this child or the child’s family pose a risk to a lone worker:  Yes No**  **Are there any safeguarding concerns?  Yes No** | | | | |
| **Nursery  Mainstream school  Special school  Independent school  Home education**  **Name of School/Nursery: School year:**  **Is child making educational progress as expected  Yes  No**  **If no, please specify:** | | | | |
| **If applicable, indicate stage on Code of Practice:** School Action, School Action Plus, EY action, EY action plus,EHCPlan. | | | | |
| **Any medical diagnosis:** | | | | |
| **Other professionals involved:** Physiotherapist Paediatrician Social worker  Health visitor Visual Impairment Teacher or Specialist Teacher Other  Speech and Language Therapist | | | | |
| **Reason for Referral:** Please describe how the child’s difficulties are affecting their everyday life  (e.g., sitting, using the toilet, dressing, hand skills):(max 100 words) | | | | |

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| **Please indicate what universal and/or targeted support has been completed/is ongoing together with the date intervention started/ended.** (See our website for universal and targeted support)<https://www.cambscommunityservices.nhs.uk/cambridgeshire-children's-occupational-therapy>  Advice Line – Parents, Carers, Schools, other Professionals  Ready to Learn Pack (please attach)  Universal and Targeted support across all areas of daily living  Housing Information  Other  **Comments/Outcomes:** |
| **If referral for Housing Need: Please state tenancy**:  **Owner Occupier  Private rental  Social housing** please state which council or housing association  **Urgent? No  Yes  Please describe why:** |
|  |
| **Please give details of what parent/carer and child are expecting from this referral:** (max 100 words) |
| **Referrer details:**  Name:  Designation:  Email address:  Contact Address:  Telephone: |

**Once completed please send this form, together with any relevant reports or letters to:**    
[CCS-TR.therapyreferrals@nhs.net](mailto:CCS-TR.therapyreferrals@nhs.net)

**Postal address:** Occupational Therapy Admin, The Peacock Centre, Brookfield’s Hospital Campus,   
Mill Road, Cambridge CB1 3DF. **Tel:** 0300 029 5050

**PLEASE SEE OUR WEBSITE FOR UNIVERSAL AND TARGETTED SUPPORT:** <https://www.cambscommunityservices.nhs.uk/cambridgeshire-children's-occupational-therapy>



**PARENTAL CONSENT**

|  |  |  |
| --- | --- | --- |
| **Consent for Referral** | | Yes / No |
| **Digital Communication** | | |
| Cambridgeshire Community Services (CCS) NHS Trust would like to send text (SMS) messages for appointment reminders and to share useful health information.  **I agree to receive text (SMS) messages**  **My preferred mobile number is:** | | Yes / No |
| We may offer appointments using video calling.  **I agree to having video call appointments** | | Yes / No |
| We would like to send your letters or reports by email, which could include personal, sensitive data. If you select yes, we will not send your letters or reports in the post, we will email them to you instead. You will receive a verification email which you must act on as confirmation that we have the right details.  We cannot email you any information without this verification.  **I agree to receive emails which could include personal information:**  **My email address is:**  Once any information has left our secure NHS email accounts, the security of the information is your responsibility. | | Yes / No |
| **Sharing information** | | |
| Are you happy for us to share your child’s record with other health services who are involved with your child’s care? | | Yes / No |
| Are you happy for us to have access to the records held by other health services involved in your child’s care? | | Yes / No |
| Are you happy for us to share information with education and the local authority i.e School / SEND? | | Yes / No |
| If required, are you happy for us to share information with Social Care? | | Yes / No |
| **SIGN:** |  | |
| **PRINT:** |  | |
| **RELATIONSHIP TO CHILD:** |  | |
| **DATE:** |  | |