**Rotherham Children’s Physiotherapy and Occupational Therapy Referral Form**

**All fields marked with \* must be completed or the form will be returned to the referrer**

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| \*Referral for (please tick): | Occupational Therapy (OT) |  | Physiotherapy (PT) |  | Joint OT/PT |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| \*Name of child or young person |  | | \*Date of Birth  (dd/mm/yyyy) | | |  | |
| \*Gender |  | | NHS Number | | |  | |
| Nationality |  | | Religion | | |  | |
| Ethnic group |  | | \* Interpreter required:  Language: | | | Yes / No | |
| Immigration status |  | |
| \*Child or young person’s main address (including  post code) |  | | | Who lives with them at this address? | |  | |
| \*Name(s) of parent(s) / carer(s) | Parent/Carer 1 |  | | | | | |
| Parent/Carer 2 |  | | | | | |
| \*Parental  Responsibility? | Parent/Carer 1 | Yes / No | \*Relationship to child: | | Parent/Carer 1 | |  |
| Parent/Carer 2 | Yes / No | Parent/Carer 2 | |  |
| \*Contact details  (Please give phone numbers and emails with parental consent) | Parent/Carer 1 |  | | | | | |
| Parent/Carer 2 |  | | | | | |
| Planned hospital discharge date (if relevant) and any related equipment needs | | |  | | | | |

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| **\*Reason for Referral**  What difficulites does the child/ young person present with and how do these impact on their everyday life?  **This information will determine priority and the most appropriate clinic. Please note if no concerns regarding the child’s function are indicated then we will be unable to accept this referral.** | | | |
|  | | | |
| **For how long have the difficulties mentioned above been affecting the child or young person?** (please circle) | | | |
| < 1 month | < 3 months | <1 year | >1 year |
| **What has been tried already to address these needs, including any adaptations or specialist equipment? How has this worked?** (\*If you are a school or early years setting, please attach a copy of your most recent support plan – *we cannot accept referrals from you without this)* | | | |
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| **\*What outcomes are you hoping to achieve from this referral?** | | | |
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| **Has the child or young person being diagnosed with any conditions?** Please list any below and include any investigations currently underway | | | |
|  | | | |
| **FOR MEDICAL PROFESSIONAL ONLY Please let us know whether there are concerns about any of the following (please tick as appropriate)**  **Please refer to referral criteria (OT/PT)** | | | |
| Altered muscle tone |  | Altered sensation |  |
| Asymmetry of movementand/or range |  | Altered range of movement |  |
| Abnormal gait pattern |  | Co-ordination |  |
| **Other** (please specify) | | | |

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| **Information about the child or young person’s abilities and development** | | | |
|  | | **Tick areas of concern** | Please give additional information on how any areas of concern impact on the childs function and attach any relevant additional information e.g. MED 1a, Ages and stages profile, handwriting samples |
| **Gross Motor** | Head control |  |  |
| Sitting |  |
| Crawling |  |
| Walking / Running |  |
| Balancing |  |
| Jumping / Hopping |  |
| Ball Skills |  |
| **Fine Motor & visual perception** | Hand use / Grips / Grasps |  |  |
| Pencil skills |  |
| Scissor skills |  |
| Judging distances |  |
| Jigsaws |  |
| Copying |  |
| **Selfcare and independence** | Bathing |  |  |
| Cutlery use |  |
| Toileting |  |
| Dressing |  |
| **Sensory** | Movement |  |  |
| Sounds/Hearing |  |
| Touch |  |
| Taste /smell |  |
| Vision |  |
| **How do these skills compare with other areas of learning and development, including concentration, listening, communication skills and cognition?** | | | |
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| **Other practitioners involved** | | | | | |
|  | Address | Telephone Number |  | Address | Telephone Number |
| **GP Name:** |  |  | **Consultant:** |  |  |
| **Health Visitor:** |  |  | **Therapists (please specify)** |  |  |
| **School / Nursery:** |  |  | **Social Worker:** |  |  |
| **Other:** |  |  | **Other:** |  |  |

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| **Please highlight below if any of the following apply for the child;** | | | | |
| Early Help Assessment | Child in Need status | Child Protection Plan | Looked after child status | Special guardianship care |

|  |  |
| --- | --- |
| **This referral must have been discussed with the Parent/Carer, they must understand what therapy may entail and have consented to this referral. Please tick to confirm consent.** | |
| \*I confirm that an adult with parental responsibility for this child or young person has consented to the referral | Please tick |

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| **Referrer information** | | | | |
| \*Name: |  | \*Relationship to child: |  | |
| \*Address: |  | | | |
| \*Contact number: |  | \*Date referral form completed: | |  |

**Please return to:**

**Children’s Physiotherapy and Occupational Therapy Department**

**Kimberworth Place**

**Kimberworth Rd**

**Kimberworth**

**Rotherham**

**South Yorkshire**

**S61 1HE**

**Or email to:** [rgh-tr.cypstherapyservices@nhs.net](mailto:rgh-tr.cypstherapyservices@nhs.net)