### PAEDIATRIC OCCUPATIONAL THERAPY - SOCIAL CARE

# **REFERRAL FORM**

[*Click here*](https://www.afclocaloffer.org.uk/uploads/afclocaloffer/document/file/154/Eligibility_Criteria_for_ISCD_Social_Care_Teams_June_2015__1_.pdf) *to check the Children with Disabilities Team Eligibility Criteria*

**Please note this is NOT a health referral form.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |  | | | | | **Gender:** | | | | | | |  | | | | |
| **DOB:** |  | | | | | **Child’s means of communication:** | | | | | | |  | | | | |
| **Address:** |  | | | | | | | | | | | | | | | | |
| **Postcode:** |  | | | | **Email:** | | | | | |  | | | | | | |
| **Telephone:** |  | | | | **Mobile:** | | | | | |  | | | | | | |
| **First Language:** |  | | | | Interpreter Required? | | | | | | | | |  | | | |
| **Parent’s/ Guardian’s name:** | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | |  |
| **Please list who lives in the family home:** | | | | | | | | | **Type of accommodation:** | | | | | | | | **Tick** |
|  | | | | | | | | | Council | | | | | | | |  |
| Housing Association | | | | | | | |  |
| Owner Occupier | | | | | | | |  |
| Private Rented | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | |
| **Name of person referring:** | |  | | | | | | **Has parent/ guardian given consent for OT involvement?** | | | | | | | |  | |
| **Address:** | |  | | | | | | | | **Postcode:** | | | |  | | | |
| **Telephone:** | |  | | | | | | | | **Email**: | |  | | | | | |
| **Relationship to child:** | |  | | | | | | | | | | | | | | | |
| **Date of referral:** | |  | | | | | | | | | | | | | | | |
| **Name and address of GP:** | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Disability/ Diagnosis:**  Please give information about the child’s medical condition and how this affects them. | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Activities of daily living:**  Please tick which box best describes the child’s abilities. | | | | | | | | | | | | | | | | | |
|  | | | **Independent – manages with no help** | | | | **Requires minimal help or equipment only** | | | | | | | | **Not possible without full assistance** | | |
| **Mobility:** | | |  | | | |  | | | | | | | |  | | |
| Indoors | | |  | | | |  | | | | | | | |  | | |
| Outdoors | | |  | | | |  | | | | | | | |  | | |
| Stairs | | |  | | | |  | | | | | | | |  | | |
| **Transfers:** | | |  | | | |  | | | | | | | |  | | |
| On/off toilet | | |  | | | |  | | | | | | | |  | | |
| On/off bed | | |  | | | |  | | | | | | | |  | | |
| On/off chair | | |  | | | |  | | | | | | | |  | | |
| In/out bath | | |  | | | |  | | | | | | | |  | | |
| **Access to:** | | |  | | | |  | | | | | | | |  | | |
| Toilet facilities | | |  | | | |  | | | | | | | |  | | |
| Bath/ shower room | | |  | | | |  | | | | | | | |  | | |
| Property itself | | |  | | | |  | | | | | | | |  | | |
| **Personal care:** | | |  | | | |  | | | | | | | |  | | |
|  | | |  | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Referrer/ Client summary of problem and indication of urgency:** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |

***Please return this form by email or post to*:**

**Email:** [socialcareot@achievingforchildren.org.uk](mailto:socialcareot@achievingforchildren.org.uk)

**Occupational Therapist Social Care**

**Children with Disabilities Team**

**Moor Lane Centre**

**Moor Lane**

**Chessington**

**KT9 2AA**

**T: 020 8547 5600 Ext 4210**

Upon receipt of the Referral, the Occupational Therapist will assess the child / young person’s needs and respond directly to the family.