

**Paediatric Physiotherapy or Occupational Therapy Referral Form**

**Any forms which are illegible or incomplete will be returned to sender. Electronic referrals are preferred.**

**Patient Details**

|  |  |
| --- | --- |
| **Name:** |  |
| **NHS Number:** |  |
| **DOB:** |  **Female/Male**  |
| **Address:** |  |
| **Telephone Number:** |  |
| **Name of Parents /** **Guardian:** |  |
| **Relationship to Child:** |  |
| **Do parents hold parental responsibility?** | **YES/NO** |
| **GP name and Address:** |  |
| **Name of School / Nursery:** |  |
| **Interpreter required?** | **YES/NO Language:** |
| **Has the patient been a resident in the UK for the last 12 months?** | **YES /NO** |

**Clinical Information**

|  |
| --- |
| **Diagnosis / Relevant medical history**  |

|  |
| --- |
| **Reason for referral/ Child’s difficulties?** |
| **Has the child been referred for Therapy intervention previously (NHS or private)?****Please state…………. Year? ……………….**  |
| **What support / advice has the child / young person received to date?****Please include any referrals to other services e.g. Education Psychology, CAMHS, SALT** |
| **Are there any Safeguarding issues?** |
| **What are the expected outcomes / aims of treatment?** |
| **Level of concern? (please tick)**  |
|  | Low | Medium | High | Any other information? |
| Child |  |  |  |  |
| Parents |  |  |  |  |
| Referrer |  |  |  |  |

**Referrer**

|  |  |
| --- | --- |
| **Full Name (please print)** |  |
| **Job title** |  |
| **Contact Address / Telephone Number** |  |
| **Signature** |  | **Date** |  |

**Please return completed form to:**

***Paediatric Therapies***

***West Acklam Centre***

***Birtley Avenue***

***Acklam***

***Middlesbrough***

***TS5 8LA***

***Tel. 01642 944506***

***Email:*** ***ste-tr.westacklamcentre@nhs.net***

**By signing this form you are confirming that you have obtained parental consent to share information with all appropriate professionals regarding this child.**