**Please note missing information will result in the referral being returned.**

**Name of Referrer** Click or tap here to enter text.**: Date of Referral:** Click or tap here to enter text.

**Name of Organisation (if relevant):** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**Contact Number:** Click or tap here to enter text.

**Email address (required):** Click or tap here to enter text.

**Relationship to Child:** Click or tap here to enter text.

**Is Parent / Child aware of referral?** [ ]  Yes [ ]  No

|  |
| --- |
| **Name of Service User:** Click or tap here to enter text. **DOB:** Click or tap here to enter text.**Gender:** Click or tap here to enter text.**Ethnicity:** Click or tap here to enter text. **First language:** Click or tap here to enter text.**Address:** Click or tap here to enter text.**Contact Number:**Click or tap here to enter text.**Email (required):** Click or tap here to enter text.**GP** Name**/Address:** Click or tap here to enter text.**School Name/Address:**Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| **Name of others living at the property** | **DOB** | **Relationship to client e.g. Parent/Sibling/Aunt**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Referral Reason (Please state if there is any broken equipment)**

|  |
| --- |
| Click or tap here to enter text. |

**Childs Diagnosis (if known)**: include patterns of movement as appropriate

Click or tap here to enter text.

Epilepsy? [ ]  Yes [ ]  No Controlled by medication: [ ]  Yes [ ]  No

Click or tap here to enter text.

Difficulty feeding due to poor posture / reflux [ ]  Yes [ ]  No

Click or tap here to enter text.

Breathing difficulties? [ ]  Yes [ ]  No

 Click or tap here to enter text.

Poor trunk / head / neck control? [ ]  Yes [ ]  No

Click or tap here to enter text.

Is the child Life limiting / palliative / end of life or terminal? [ ]  Yes [ ]  No

Click or tap here to enter text.

**Previously known to Occupational Therapy.**

New to service? [ ]  Yes [ ]  No

Is the child hoisted? [ ]  Yes [ ]  No

If yes, is the hoist free standing or fixed to the ceiling?

Click or tap here to enter text.

If yes, are any of the slings ripped, frayed, damaged or instruction labels illegible?

Click or tap here to enter text.

Current weight:Click or tap here to enter text. Current Height**:** Click or tap here to enter text.

Has the property been previously adapted? [ ]  Yes [ ]  No

Click or tap here to enter text.

Does the child have any specialist postural seating at present? [ ]  Yes [ ]  No

Click or tap here to enter text.

Please state any other equipment already provided:

Click or tap here to enter text.

**Please email completed form to:**

access\_team@sandwellchildrenstrust.org