**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** |
|  |  |  |
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|  |  |  |

**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](mailto:access_team@sandwellchildrenstrust.org)