Please note: **ALL** boxes on this form must be fully completed in order for the request for assessment to be processed. Any incomplete forms will be returned to the requester.

**BURY PAEDIATRIC**

 **OCCUPATIONAL THERAPY REFERRAL**

**PLEASE SEND COMPLETED REFERRAL TO** **spoa.fax@nca.nhs.uk**

**Child/Young Person’s details**

|  |  |
| --- | --- |
| Name: | Date of birth: |
| Gender: | NHS number: |
| Address: | GP: |
| Parent/Guardian 1: Please provide name/address/contact numberParental responsibility? Yes / No | Parent/Guardian 2: Please provide name/address/contact numberParental responsibility? Yes / No |
| Languages spoken at home: | Interpreter required? Yes / No |

**Safeguarding**

|  |
| --- |
| Please tick if the child is subject to any of the following?* Child Protection Plan
* EHFS Plan (Early Help Family Support Plan)
* CIN action plan (Child In Need)
* TAF action plan (Team Around the Family)
 |
| If ‘**yes**’ to the above please provide name and contact details of key person: |
| Is this a **Looked After Child?** Yes / No If **No,** please skip to the Health section and continue  |
| Person with parental responsibility |  |
| Consent for referral given by |  |
| Social Worker details: Name, address, contact number & placing authority required |  |
| Legal Status |  |
| Foster Carer / Carer name, address & contact number |  |
| Who can attend appointments? |  |
| Restrictions: Regarding information sharing during appointments and in reports / report circulation |  |

**Health and Allergies:**

|  |  |  |
| --- | --- | --- |
| Any known allergies  | No | Yes: Details |
| Please tick any other professionals involved and provide names and contact information if known:* Audiology
* ENT
* Family Support Worker
* School Nurse
* Occupational Therapist
* Physiotherapist
* Paediatrician
* Social Worker
* Other (please state)
 |

**Education**

|  |
| --- |
| Name, address & telephone number of nursery / pre-school (if appropriate): |
| Please give details of the current level of support: e.g. SEN support / EHCP |
| Current developmental tracking information: please indicate whether these are above or below age expectations |
| Has the child been seen by any of the following services:* Educational Psychology
* Additional Needs Team

Please attach a copy of any paper work related to these assessments |

**Paediatric Occupational Therapy Referral Criteria:**

**Children and Young People will be accepted onto our waiting list if they are:-**

* **Aged 0-18 (31st August after their 18th birthday or until 19 if they attend Elmsbank Special School)**
* **Have a Bury GP**

**Clinical referral criteria for neuro disability:**

* **Neurological impairment e.g. Cerebral Palsy / Neuromuscular disorder / Genetic**
* **Post orthopaedic or neurosurgical intervention for neuro disability**
* **Development delay**
* **Are on the Neonatal following pathway**
* **Require assessment for specialist equipment for home and education setting (this excludes bathing equipment for aged 5+)**

**Clinical referral criteria for short-term pathway:**

* **This service provides assessment and advice for children who are experiencing functional difficulties with activities of daily living, (such as handwriting, scissor skills, and cutlery skills), difficulties associated with Hypermobility, DCD, and Dyspraxia. Once the assessment and advice is complete the child will be discharged.**

**We are unable to formally diagnose Dyspraxia / DCD, this must be completed by a Paediatrician.**

|  |
| --- |
| **Exclusion criteria:****PLEASE NOTE WE DO NOT ACCEPT REFERRALS FOR:-*** **Children not registered with a Bury GP**
* **Non-symptomatic Hypermobility**
* **Assessment or advice for housing adaptations – Refer to Social Services O.T. 0161 253 6846**
* **Assessment for bathing solutions for children 5 and over – Refer to Social Services O.T.**
* **Provision / assess / advice on wheelchairs, buggies or pushchairs – Call the Posture and Mobility Centre on 01706 676 349**
* **Assessments of sensory based needs**
 |

**Reasons for this request for assessment:**

|  |
| --- |
| **Reason for Referral: (this must include any diagnosis / current investigations):**  |

**Requester details:**

|  |  |
| --- | --- |
| Name: | Address and contact number: |
| Job Title: |

**Consent:**

 **Parent/Carer Signature** **Date**

|  |  |  |
| --- | --- | --- |
| I confirm that I am the parent / guardian with parental responsibility, or foster carer with delegated authority, and that I consent to this referral to the service for assessment and treatment.I consent to liaison with other professionals relevant to my child’s care. |   |  |

 **Requester Signature** **Date**

|  |  |  |
| --- | --- | --- |
| I confirm that I have discussed this request for assessment with the parent / guardian and that they have given their express consent to this request for assessment. I am aware / have explained to the parent/guardian that this request for assessment is subject to triage and that the child may be signposted to another agency better able to meet the child’s needs, or further information may be requested before the referral to the service is accepted. |  |  |

|  |
| --- |
| **Please send completed form to:** **spoa.fax@nca.nhs.uk** **Single Point of Access** |

**Any queries contact our office on 0161 206 0668**