South West Yorkshire Partnership NHS
NHS Foundation Trust

Children's Therapy Referral Form

All fields marked with * must be completed or the form will be returned to the referrer

*Referral for (please tick):	Occupational Therapy	Physiotherapy	Joint OT/PT

*Name		*Date of Birth (dd/mm/yyyy)	
Preferred Name		NHS Number	
*Gender		Preferred Pronouns	
Nationality		Religion	
Ethnic group		* Interpreter required: Language:	Yes / No
Immigration status			
*Address (including post code)			
*Contact telephone number:		Home / Mobile number:	
Child's principal carers			
*Name			
*Parental responsibility	Yes / No	*Relationship to child:	

Diagnosis (Include investigations undertaken to date):
*Reason for Referral What difficulites does the child present with and how do these impact on their function? **This information will determine priority and the most appropriate clinic. Please note if no concerns regarding the child's function are indicated then we will be unable to accept this referral.**
What are your expectations of therapy?

Duration of symptoms (please circle)			
< 1 month	< 3 months	<1 year	>1 year

Relevant Information			
		Tick areas of concern	Please give additional information on how this impacts on the childs function.
Gross Motor	Head control		
	Sitting		
	Crawling		
	Walking / Running		
	Jumping / Hopping		
	Ball Skills		
Fine Motor	Hand use / Grips / Grasps		
	Pencil skills		
	Scissor skills		
ADL's	Bathing		
	Cutlery use		
	Toileting		
	Dressing		
Sensory - Treatment will be a Sensory Workshop education session			
Sensory	Movement		
	Sounds		
	Touch		
	Taste /smell		
	Vision		
Please attach any relevant additional information; this could include MED 1a, handwriting samples etc…			

Other Agencies Involved					
	Address	Telephone Number		Address	Telephone Number
GP Name:			**Consultant:**		
Health Visitor:			**Associated Specialist in Paediatrics:**		
School / Nursery:			**Social Worker:**		
Other:			**Other:**		

Please highlight below if any of the following apply for the child;				
Early Help Assessment	Child in Need status	Child Protection Plan	Looked after child status	Special guardianship care

This referral must have been discussed with the Parent/Carer, they must understand what therapy may entail and have consented to this referral. Please tick to confirm consent.		
*Parental consent		

Referrer information			
*Name:		*Relationship to child:	
*Address:			
*Contact number:		*Date referral form completed:	
Will parents/carers need additional support to attend their appointment?		Yes/No (please give details)	

Please return to:
Children's Therapy, The Oaks Building, Kendray Hospital, Doncaster Road, Barnsley, S70 3RD
Telephone number: 01226 644396

Or email to: barnsleychildrenstherapy@swyt.nhs.uk