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States of Guernsey
Children and Family
Community Services

Children and Young People and Families (CYPF)
Occupational Therapy Referral Form

Parental Information and Consent

Following this referral, support and guidance may be offered to the family via the referring therapist, and/or a referral may be accepted by the most appropriate services. In addition, onward referral to professionals outside the referral may be recommended.

The information in this form will be shared and the content will be discussed to establish what support is required. Further requests for information from Education, School, Nursery, GP or other areas of Health & Social Care, may be required. This will ensure the service has the right information, on which to base any decision about advice offered or referrals accepted.

We will hold data in accordance with our retention and destruction policy. A copy of HSCs full fair processing notice can be found at https://gov.gg/hscprivacy

Please sign to confirm you consent to your Child being referred:

Please check to confirm verbal consent gained: ☐

Print Parent Name:

……

Relationship to Child/ Young Person:

Date: ……..

……..

Referral Form

Information for Professionals

All referrals are to be submitted electronically to the Children, Young People and Families Occupational Therapy Service: CYPFOCCUPATIONALTHERAPY.REFERRALS@GOV.GG

Before submission, please place an X in the box to confirm you have:

1. Discussed the Parental Information with parents and have gained signed consent ☐
2. Completed the General Information section ☐
3. Completed the respective Occupational Therapy details ☐

Any Referral forms missing the above stated information will be rejected and returned to you.

General Information

Child/Young Person's Personal Details
CYP Name: **DOB:** **Address/Main Residence:** **Post Code:** **Contact No.:** **Parents/Carers Email:** **CYP Pre-School or School:** **CYP Pre-School / School SENCO:** **GP's Name:** **GP Surgery:** **Name/'s of Parent/Carer's with Parental Responsibility:** **1.** **2.**

Referral and Referrer Details
Name: **Date of Referral:** **Referrer's Email:** **Referrer's Contact No.:** **Referrer's Role/Profession:**

Child/Young Person's Wider Details
If child is cared for by anyone other than the above – please provide address (include if parents separated) **Name of Parent/Carer:** **Address:** **Post code:** **Contact No.:** **Email:**
What is their ethnicity?

Questions about the Child/Young Person
What is their main method of communication? (Verbal / Signing / Communication aid – please give details)
What is the first language spoken in the family home?
List any other language spoken in the family home:
Are they subject to a: CIN / LAC / CP Plan? **If so, who is the lead professional?**

Sibling/s Details (Name/s, ages and whether they live with the Child/Young Person?)		
Name: _____	Age: _____	Same residence? Yes / No
Name: _____	Age: _____	Same residence? Yes / No
Name: _____	Age: _____	Same residence? Yes / No
Name: _____	Age: _____	Same residence? Yes / No

Provide a summary of the child's physical, psychological, and emotional needs including any diagnosis given:

Provide a summary of any social care needs e.g., MASH referrals, safeguarding concerns, domestic violence:

Please indicate by placing an X in the box, for who else is currently involved in supporting the child/young person and their family? *This may include, but not limited to:*			
GP		Speech and Language Therapist	
Paediatrician		Physiotherapist	
Teacher		Autism Diagnostic Service	
Social Worker		CAMHS	
Educational Psychologist		Other:	
Clinical Psychologist			
School Nurse/Health Visitor			

Occupational Therapy

Referral Criteria:

1) *Infants and pre-school aged children with 2 or more developmental concerns who require early assessment and intervention.*
2) *School-aged children with 2 or more significant functional difficulties impacting on their ability to access the curriculum, their functional independence, or their ability to participate in everyday activities.*
3) *Children and young people who require specialist aids, adaptations, and equipment for their safety, or to support their participation and functional independence.*

What are the main **difficulties/concerns** you would like Occupational Therapy to help with?

Describe the **impact** these difficulties have on the child/young person's **participation and independence**:
(Please give examples)

1. At Home:

2. At School:

3. Within the Community:

What **strategies** have you already tried to address the difficulties or concerns raised over the past 3 months:

Please give the reason why you feel these strategies have not worked and what additional support is required:

Please place an **X** in the box for the **main areas of concern** you have for the child/ young person, giving examples:

Participation		
Emotional Well Being		
Self-Esteem and Confidence		
Motivation		
Organisation		
Behaviour		
Sensory		
Awareness of Safety		
Emotional Well Being		

Physical Environment		
Pain		
Moving and Handling		
Transfers		
Seating		
Bathing and Toileting		
Physical Access at Home, School and within Community Settings		

Education Setting		
Following Instructions		
Following Daily Routines		
Attention and Concentration		
Organisation at School		
Working Independently		
Using Scissors / Ruler		
Pencil Grasp and Handwriting		
PE		

Self-Care / Independence		
Eating/drinking		
Toileting		
Bathing		
Dressing		
Grooming		
Brushing Teeth		
Sleep		

Leisure and Play Skills		
Ability to Play Independently		
Playing Age-Appropriate Games and Toys		
Playing with Others		
Extra-Curricular Activities		

INTERNAL ADMINISTRATION USE ONLY

OCCUPATIONAL THERAPY SERVICE

Reason for Referral	**Primary Concern**	**Please Select**	
	Developmental/Comprehensive Ax		
	Equipment Ax		
	Pre-School MDT Ax		
	Environment, Safety and Access Ax		
	Bespoke Sensory Consultation		
	Sensory Advice Consultation Clinic		
Add to Waiting List		**Please Select**	
	Yes	**Within 3 months**	
		Within 3 to 6 months	
		At least 6 months	
	No		
Assign to Caseload	**OT1**		
	OT2		
	OTA		
	SAC		

Please Create, Send Upload the following letter and Upload to RIO:

Type of Letter Required	**Please Select**

Letter of Acceptance to Referrer and cc Parents (& SENCO if applicable)			
Declined Referral Letter to Referrer and cc Parents (& SENCO if applicable)			
OT Initial Assessment Letter	**Date:**	**Time:**	
SAC OT Appointment Letter to Parents	**Date:**	**Time:**	
SAC OT Appointment Letter to Referrer	**Date:**	**Time:**	
SAC Appointment Letter to Other Name:	**Date:**	**Time:**	

Please Include the Following Forms:

Questionnaire/Leaflet Required	Please Select
Infant Care Giver Sensory Profile Questionnaire	
Toddler Care Giver Sensory Profile Questionnaire	
Child 3 – 14 Care Giver Sensory Profile Questionnaire	
School Companion Sensory Profile Questionnaire	
OT Initial Parent Questionnaire (IPQ)	

ALL LEAFLETS TO BE SENT WITH CORRESPONDENCE WILL BE INCLUDED WITH THIS REQUEST