**SOCIAL CARE CHILDREN’S OCCUPATIONAL THERAPY (OT) REFERRAL FORM**

 **Please return completed referral to:** **child-occupational-therapy@royalgreenwich.gov.uk**
Please complete all the boxes. If there is insufficient space, please continue on a separate sheet.

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|  **CHILD / YOUNG PERSON’S DETAILS** |
| **Name:** |  |
| **DOB:** |  |
| **Home Address:** |  |
| **GP Details:** |  |
| **School / Education:** |  |
| **PARENT / GUARDIAN / CARER’S DETAILS** |
| **Name/s:** |  |
| **Contact Details:** |  |
| **Relationship to Child:** |  |
| **Preferred Language:** |  | **Interpreter required:** | **Yes / No** |
| **People living in the property:** |  |
| **Additional needs in the family:** |  |
| **CHILD’S MEDICAL CONDITION / NEEDS** |
| **Diagnosis / Conditions:**  |
| **Height:** |  | **Weight:** |  |
| **REASON FOR REFERRAL** |
| **Please list the specific difficulties / areas of concern that you would like Social Care OT support with:** |
| **HOME ENVIRONMENT** |
| **Type of Property:**(please indicate) | **Flat**  | **Maisonette**  | **House**  | **Bungalow** | **Other** |
|  | **If flat, what level of flat:** |  | **Is there a lift?** | **Yes / No** |
|  | **If Other, please describe:** |  |
| **Ownership of Property:** | **Owner** **Occupied**  | **Greenwich** **Council**  | **Housing Association** | **Privately** **Rented**  |
|  | **Name of Housing Association:** |  |
| **Access to Property:** |  **Level access** | **Steps – How many?**  | **Ramped**  | **Steplift**  |
| **Rooms in Property:**(e.g. Downstairs: living room, toilet; Upstairs: 3 x bedrooms, bathroom) | **Downstairs Rooms:**  |
| **Upstairs Rooms:**  |
| **Date Moved into Property:** |  | **Mutual Exchange?** | **Yes / No** | **Housing OT Involved?** | **Yes / No** |
| **Existing Adaptations in the Property:** | **Level Access Shower**  | **Ramp/s** | **Through Floor Lift**  |
| **Other:**  |  |
| **Existing Equipment in the Property:** (e.g. shower chair, hoists, slings, profiling bed, wheelchair) |  |
| **Previous OT Involvement:**  |  |
| **Other Professionals****Involved:** |  |
| **REFERRER’S DETAILS** |
| **Name:** |  |
| **Designation / Role:** |  |
| **Contact Details:** |  |
| **Date of Referral:**  |  |