Westminster Special Schools
Training & Outreach

# WESTIMINSTER EDUCATION OUTREACH SERVICE

# REFERRAL TO CHILDREN'S OCCUPATIONAL THERAPY

**Please return the form to:**
Occupational Therapist
Westminster Outreach Team, Queen Elizabeth II Jubilee School, Kennet Road, London, W9 3LG

<table>
<tr><th colspan="4">GENRAL INFORMATION</th></tr>
<tr><td colspan="2">Child's Surname:</td><td>M / F</td><td>Name of the School:</td></tr>
<tr><td colspan="3">Child's first name:</td><td rowspan="2">Address:<br><br>Postcode:</td></tr>
<tr><td colspan="3">Date of birth:</td></tr>
<tr><td colspan="3" rowspan="2">Address:<br><br>Postcode:</td><td>Phone number:</td></tr>
<tr><td>YEAR:</td></tr>
<tr><td colspan="3">Name of parents/ carer:</td><td>SENCO:<br><br>Class teacher:<br><br>Key worker:</td></tr>
<tr><td colspan="2">Telephone:</td><td>Mobile:</td><td>STATEMENT</td></tr>
<tr><td colspan="3">1st Language:<br><br>Interpreter required? Yes/No</td><td>Does the child have a statement of needs?<br><br>Yes ☐ No ☐</td></tr>
<tr><td colspan="3" rowspan="2">GP:<br><br>Address:</td><td>Is OT provision specifically stated in part 3 of their Statement?<br><br>Yes ☐ No ☐ if no contact CYPOT</td></tr>
<tr><td>Has the child been referred to CENMAC?<br><br>Yes ☐ No ☐</td></tr>
<tr><td colspan="4"><u>If the child does not have Occupational therapy in part 3</u> of their statement please refer the child to children and young people's Occupational Therapy (CYPOT) on 0208 846 6836</td></tr>
<tr><td colspan="4">Other professionals involved and contact details (if known):</td></tr>
</table>

## SPECIFIC INFORMATION

**Medical/Other information** *(any known condition or diagnosis, medications, information from previous assessment, hearing, vision, communication difficulties)*

**What are the child's difficulties in the classroom?**

**What strategies have been tried to assist this child? What has or has not worked?**

**Main Reasons/priorities for referral to Occupational Therapy**

**Any additional information:**

**Referred by:** **Designation:**

**Address:**

**Signed:** **Date:**

*In order to assist the child it may be necessary for the Occupational Therapist to access medical information which is relevant to the child's development. Please ask the parent to sign that (a) they agree to this referral being made and (b) that they agree medical information may be obtained.*

**Signature of Parent/ Carer:**
(or evidence that parent/ carer has been consulted and agreed to this referral)

**Name of the parents/carer:** **Relationship:**

**Date:**