Childrens Therapy
Referral for Assessment
School-Age

Referred to	Occupational Therapy	☐
	Physiotherapy	☐
	Speech and Language Therapy	☐

The child you are referring

Name of Child			Date of birth
Surname(s) of parents			Next of Kin
Name of Mother			
Name of Father			
Address			GP
Postcode			
Telephone numbers	Home	Work	Mobile
e-mail address:			
School		Year group	Teacher

You – the referrer

Referred by	Job title
Date of referral	Telephone number
	Email

Other professional agencies involved with this child? Tick box

Paediatrician	☐	Physiotherapist	☐
Psychologist	☐	Social services	☐
Occupational therapist	☐	Private therapist	☐
ENT/Audiology	☐	CAMHS	☐
School Nurse	☐	Dietician	☐

Languages spoken in the home

English	☐	Other(s)	
Is an interpreter required	☐	Are there any concerns around parental literacy	

Parental consent to referral – You MUST seek parental permission prior to referral

✓	I agree to this referral
✓	This referral has been explained to me and I understand the reason for this referral
✓	I understand that if I fail to attend my child may be discharged from the service
✓	I consent to sharing of relevant information e.g. written reports, with other professional staff involved with my child
Print full name	

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Signature				
Referral Information				
Is the child on the special needs register	Yes	☐	No	☐
Does the child have a diagnosis of general or specific learning difficulty or developmental delays	Yes	☐	No	☐
If 'yes' please describe				
School Provision	Mainstream	☐	Unit	☐
If a monitored programme is considered appropriate, would there be Provision to carry out the programme? (individual or small group work e.g. 3 x 30 minutes per week)	Yes	☐	No	☐
Are there any safeguarding concerns?	Yes	☐	No	☐
Is this a looked after child?	Yes	☐	No	☐
Reasons for referral to Children's Therapy: (Please include the impact of difficulties on child's daily function)				
What strategy or system does the child currently use? (i.e. PECS, fine, gross motor or IT programmes, language link)				
What supports/equipment assists the child's function? (i.e. sloping desk, slings, sensory resources or specialist seating)				
Has it made a difference	Yes	☐	No	☐
Description of communication difficulty				

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	Verbal comprehension and following directions **Note**: Please provide the front page of the Language Link screen with the score and errors	☐
	General social and communicative interactions	☐
	Expressive language (vocabulary, sentence production, grammar)	☐
	Speech Pronouncing the following sounds: ..... **Note**: Please provide the front page of the Speech Link screen and/or a list of errors **Note**: It is not unusual for children under 8 years to have difficulty with 'r' and 'th' Therefore, referral for these sounds only would be inappropriate. Also, a referral for a lisp only before adult teeth have grown is inappropriate.	☐
	Stammering, dysfluency or intonation (melody of speech)	☐
	Voice quality: huskiness, loss of voice, pain when speaking	☐
Please attach any recent reports (e.g. Educational Psychology) to this referral.		

Background Information

Developmental and medical history information including current treatments/medications:

Where there any complications in pregnancy or birth?

Is there any family history of medical diagnoses? (autism, specific learning difficulties, developmental delay, congenital concerns)

Does the child have any allergies	Yes ☐ No ☐		
Has the child had any of the following			
Frequent colds	Yes ☐ No ☐	Frequent chest infections	Yes ☐ No ☐
Frequent ear infections	Yes ☐ No ☐	Asthma	Yes ☐ No ☐
Tonsillitis	Yes ☐ No ☐	Concerns about vision	Yes ☐ No ☐
Concerns about hearing	Yes ☐ No ☐		

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Please return the completed form to:

Children's Therapy Service
Community Health Centre
Westmoreland Road
Douglas
IM1 4QA

Or email to: **Childrenstherapyteam@gov.im**