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| **Therapy Referral Form for Community Physiotherapy**  **For children living in**  **Cornwall and the Isles of Scilly**  *Please note that home addresses with the following postcodes should be referred to the Plymouth Team via Emma Mees, Therapies Lead, Plymouth CDC, Scott Business Park, Beacon Park Road, Plymouth PL2 7PQ:*  ***EX22, EX23, PL10 to PL18*** | |
| CHILD’S NAME: |  |
| CHILD’S DATE OF BIRTH: |  |
| PARENT’S NAMES (or those with parental responsibility): |  |
| PARENT/CARER CONSENT: | **If the child is experiencing pain or their condition has changed parents/carers are advised to contact their GP before making this referral.**  **On occasions, sensitive information may need to be shared professionals in another service. Please note anyone aged over 13 years, who is deemed competent, can give their own consent. This may be with or without parental consent.**  **By ticking this box, you are confirming that the following verbal consent has been given: “I agree to this referral and to my information being shared with agencies.”**  **Name of person giving consent (Parent or Guardian/Child over 13 who is deemed competent)**  **…………………………………………………………………..**  **Date: ……/……/……**  **If you feel it is appropriate to submit this referral without consent from the young person, please contact the Physiotherapy Service  to discuss this.**  I give permission for this referral, and for the Physiotherapy service to obtain further information from my child’s school if necessary.  Parent/Carer signature: ……………………………………………………..  Please print name: …………………………………………………………….  Date: …../…../…… |

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| HOME ADDRESS:  POSTCODE: |  |
| HOME TEL:  MOBILE:  EMAIL: |  |
| GP’s NAME & ADDRESS: |  |
| NAME OF CHILD’S SCHOOL/NURSERY AND CONTACT DETAILS: |  |
| Interpreter required?  PLEASE NAME OTHER PROFESSIONALS OR SERVICES YOUR CHILD HAS BEEN INVOLVED WITH: | Y/N Preferred language: |
| NAME OF REFERRER: |  |
| ADRESS:  POSTCODE: |  |
| TELEPHONE NO.: |  |
| POSITION: ARE YOU THE CHILD’S PARENT/CARER/SENCO/HEALTH PROFESSIONAL? |  |
| REASON FOR REFERRAL: |  |

Please describe the child’s abilities in the areas below, as completely and accurately as possible.

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| **MOVEMENT SKILLS** | **Y / N** | **Comments** |
| Delayed with development, or has difficulty with, rolling,  sitting, crawling, walking |  |  |
| Child has difficulty co-ordinating both sides of the body |  |  |
| Child struggles during PE at school |  |  |
| Child’s movements appear clumsy |  |  |
| Stamina – does the child tire quickly? |  |  |

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| **FINE MOTOR SKILLS** | **Y / N** | **Comments** |
| Child has difficulty manipulating objects with hands |  |  |
| Child is unable to grasp and release objects in hands |  |  |
| Child is unable to use both hands together during play |  |  |
| Child has difficulty with handwriting / pre-writing |  |  |

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| **SENSORY NEEDS** | **Y / N** | **Comments** |
| Child responds unusually to sensory stimulation  e.g. touch / texture on skin / lights / movement /textures in mouth / smells / sounds |  |  |
| Child seeks out or avoids extra forms of movement eg running, spinning, climbing and jumping |  |  |
| Child engages in self-stimulation/harmful behaviours to either themselves or others |  |  |

**(If you have ticked any of the above boxes, please give examples of the impact on the child’s day to day activity)**

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| **ACTIVITIES OF DAILY LIVING** | **Y / N** | **Comments** |
| Child requires extra help when eating/drinking |  |  |
| Child requires extra help with dressing |  |  |
| Child requires extra help with using a toilet |  |  |
| Child has problems with bathing/teeth brushing/grooming |  |  |

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| **GENERAL BEHAVIOUR** | **Comments** |
| Attention and concentration: |  |
| Organisation and planning skills: |  |
| Does their behaviour affect their everyday activities, and if so, what is the impact for them? |  |
| **OTHERS INVOLVED** | **Comments** |
| Others involved in child’s care and how they are helping the child currently: |  |

**On completion of the form please send to:**

Children’s Community Therapy Service

Dolphin House

Royal Cornwall Hospital

TRURO

TR1 3LJ

Tel: 01872 254531

Email: [rch-tr.ChildrensCommunityTherapy@nhs.net](mailto:rch-tr.ChildrensCommunityTherapy@nhs.net)