

**REFERRAL FORM**

**Oxfordshire Children’s Integrated Therapy Services**

**Website:** [**www.oxfordhealth.nhs.uk/cit**](http://www.oxfordhealth.nhs.uk/cit)

**Use this form to request support from Children’s Occupational Therapy, Physiotherapy & / or Speech & Language Therapy for Children Aged 5 years (Year 1) and above**

**ALL SECTIONS MUST BE COMPLETED.**

**IF THERE IS MISSING INFORMATION INCLUDING MISSING SUPPORTING PAPERWORK THE REFERRAL WILL BE RETURNED.**

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| **Which Service/s are you requesting involvement from? Please tick:**  **OT**  **Physio  SLT  Unsure** |

***NB: All sections must be completed or the referral will be returned***

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| **Child/Young Person** | **Child’s Forename:**  **Child’s Surname:** | **Date of Birth:**  **Age:** |
| **Address:**  **Postcode:**  **Ethnicity:** | **Parent/Carer names:**  **Current family Structure/Home situation:** |
| **Parent/Carer Tel. No:**  **Mobile:**  **E-mail:** |
| **Gender: Male  Not Known**  **Female  Not specified** | **Language spoken at home:**  **Is an interpreter required? Yes / No** |
| **School Address:**  **School Year:** | **GP Name / Address:** |
| **School Tel No:** |
| **EHCP:** | **NHS No:** |

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| **Referrer** | **Referrer’s Name:** | **Address:** |
| **Tel No:** **Mobile:**  **Email:** |
| **Date of Referral:** | **Role:** |

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| **Consent** | **Parent / Carer/Young Person (over 12 ) confirmation that:**   * **I agree to this referral:** (Tick to confirm)   **Professionals need to work together in order to provide you/your child with the support that meets you/your child’s needs. They may need to communicate with other professionals who are involved with you/your child.**   * **I consent to information being shared as noted above** (Tick to confirm)   **Signed: Name: Date:**  ***NB: We cannot accept referrals if not signed by Parent/Carer/young person (if 12+)*** | |
|  | | |
| **Please tick to confirm that there is no current Communication & Interaction involvement with this child/young person** **(tick to confirm )** | | |
| **Please attach relevant information from:**   * **Paediatrician**   **Name (if known):**   * **Education Psychologist**   **Name (if known):**   * **Specialist Advisory Teacher**   **Name (if known):**   * **Social Worker**   **Name (if known):**   * **Other: Please specify**   **Name (if known):** | | **Please attach any relevant documents:**  **(Tick all that you have enclosed)**   * **EHCP** * **Letter of diagnosis/CAMHS/Multi Professional Assessment** * **Most recent Goals / Outcomes** * **Other, please specify** |
| **Medical Details/Diagnosis:**  *Please give as much information as possible and include any supporting paperwork with the referral if necessary.* | | |
| **Reason for referral; including current concerns:**  *Please give as much information as possible and include any supporting paperwork with the referral if necessary. For SLT school referrals, please ensure supporting paperwork is attached.* | | |
| **Further information; Parent/Carer/Young person would like others to know:** | | |
| **Summary of identified Safeguarding Concerns (if applicable):**  *Brief, factual information only to be given.* | | |

**Send completed form to:** [**oxonchildrens.therapies@oxfordhealth.nhs.uk**](mailto:oxonchildrens.therapies@oxfordhealth.nhs.uk)

**Version6 03/2023 to be reviewed February 2024**