

**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       [ ]**
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| **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**

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