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| Occupational Therapy Parent/Carer Form |
| |  |  | | --- | --- | | Pupil Surname: |  | | Pupil Forename(s): |  | | Date of Birth: |  | | Name of Person Completing this Form: |  | | Relationship to Child/Young Person: |  | | Full Name of School: |  |  |  |  | | --- | --- | | **MEDICAL INFORMATION**  Please provide the following information | | | Name of GP: | | | Address of GP Surgery: | | | Telephone Number of GP Surgery: | | | Name of Paediatrician: | | | Address of Paediatrician: | | | Telephone Number for Paediatrician: | | | Diagnosis (if any) and Date: | | | Please state any other professionals involved: | | | Medical History (including developmental milestones, family & social history): | | | Birth History (any concerns around birth and neonatal care): | | | Is your child or young person on an NHS waiting list?  Yes No | | | **ASSESSMENT DETAILS** | | | Please state the reason you wish to refer your child/young person to Occupational Therapy.  Please add as much detail as possible. | | | What do you wish to achieve from the assessment? | | | What goals does the child/young person have? | | | What strengths and interests does the child/young person have? | | | What do they find challenging? | | | Signature of Parent/Carer: |  | | Name (in capitals): |  | | Date: |  | |