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|  Occupational Therapy Parent/Carer Form |
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| Pupil Surname: |  |
| Pupil Forename(s): |  |
| Date of Birth: |  |
| Name of Person Completing this Form: |  |
| Relationship to Child/Young Person: |  |
| Full Name of School: |  |

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| **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: |  |

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