 **Senara OT Referral Form**

Please complete this form electronically and return to info@senaraot.com

This information is kept confidentially and will only be shared with people that you have given us permission to share it with, unless we feel that the safety of the child or an adult is at risk. At which point we will share the information with the relevant authority.

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| Name of Referrer: |  | Date: |  |
| **Parent/healthcare professional:** |  | **If heath care professional, please provide contact details:** |  |
| **Have the parents/guardians consented to this referral?** |  | **Any other details:** |
| **Child’s Name:** |  |
| **Date of Birth & Age:** |  | **Is the child adopted?** |  |
| **Parents/Guardians names:** |  | **Occupation(s):** |  |
| **Address(es)** |  | **Postcode(s):** |
| **Email address(es):** |  |
| **Home phone number:** |  |
| **Mobile:** |  |
| **Allergy Information:** |  |
| **Diagnosis:** |  | **Diagnosed by:** |  |
| **Name of Family Plus Worker:** |  | **Name of Pediatrician:** |  |
| **Other heath care professionals involved in supporting this child? If so, please provide details:** |  | **Is referral required to feed into EHCP? If so, provide details/deadline information:** |  |
| **Is this referral to contribute to a Tribunal process?****Please provide all details:** |  |
| **Name of School:** |  | **Name of Teacher & Class:** |  |
| **SENco name:** |  | **SENco email:** |  |
| **School address:** |  |
| **School telephone:** |  |
| **Are the school aware of this referral?** |  |

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| Reasons for referral?Main difficulties, please list. |  |
| Who is funding assessment? Please select | **Parents** | **School** | **Council** | **Adoption support fund** |
| Who is funding treatment? Please select | **Parents** | **School** | **Council** | **Adoption support fund** |
| Please provide funding details: | **Contact name:****Job Title:** | **Email:****Phone:** |

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| ***SENARA OT ADMIN USE ONLY*** |
| ***Referral reviewed by therapist:****initials and date* *TJ / MB/ SJ / KJ* |  |
| ***Outcome of review:****accepted/declined* | ***Actions for booking:****Which clinician is responsible:**Which assessment/therapy package is required:* *AX Location – school, clinic or home:* *Any additional actions ie SPM forms etc:* |