CHILDRENS OCCUPATIONAL THERAPY REQUEST FOR ASSISTANCE

UNLESS THIS FORM IS COMPLETED IN FULL IT MAY BE RETURNED TO THE PERSON MAKING THE REQUEST, FOR FURTHER DETAILS

Date r'cvd (Admin only):		**Admin use - Unit no:**
Child's Name: (Male/Female)		**Person making request:**
DOB/CHI:		**Designation:**
Address:		**Person making request - full contact address with postcode:** **Telephone number:**
Full name & Relationship of Main Carer:		**GP Name:** **Address:** **Postcode:**
Home Phone: **Mobile No:** **Alt Contact No:**		**School/Nursery (Name & Class)**

What are your main concerns about the child at the moment? (self care i.e. – dressing, toileting, feeding, bathing))	
How is this affecting the child/family?	
Is anyone else concerned? (education, family member)	
Is the child receiving additional support from other services? (involvement of other agencies)	
Has the child received any additional support in the past, including O.T.? (please include dates seen and therapist)	

What things have you tried so far to help the child? Has anything helped? e.g. strategies and/or equipment	
What do you expect from the O.T service	
Other Information – **i.e.: Diagnosis, any child protection issues or Family circumstances.**	

Parents / guardians have consented to this request: YES /NO

If this request of assistance is deemed to be more appropriate for Physiotherapy instead of Occupational Therapy, do you give consent for the information to be passed to their service? YES / NO

Signature of person making request:	**Date sent:**

Please forward this form to:

Carol McVickers, Occupational Therapy Co-ordinator
AHP Childrens Services
Administration Area 4
Stirling Community Hospital
Livilands
Stirling
FK8 2AU

Tel: 01786 454551