Referral Form

**Building Underdeveloped Sensory Systems**

**Child / young person referred**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |

**Details of people living in the family / household**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child  |  |
|  |  |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child |  |

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child |  |
|  |  |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child |  |

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Gender |  |
| Relationship to referred child |  |

**Contact information for parent(s)**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
|  |  |
|  |  |
| Telephone – Home Landline(can messages be left) |  |
| Telephone – Personal Mobile(can messages be left) |  |
| Telephone – Work(can messages be left) |  |
| Email |  |
| Availability |  |

**Referrer’s information**

|  |  |
| --- | --- |
| Name |  |
| Role |  |
| Address |  |
|  |  |
|  |  |
| Telephone numbers |  |
|  |  |
| Email |  |
| Working days/hours |  |
| Date of Referral |  |

**Main reason for referral**



**Social Care professionals and School staff involved with the child currently**

|  |  |
| --- | --- |
|  | Email addresses and Contact Telephone Numbers |
| Names of current social care professionals |  |
|  |  |
| Name and contact details of current school |  |
| Name of current teacher or support teacher who knows child best |  |
| Name of school SENCO |  |

**Information about the child / young person**

|  |
| --- |
| Is there any history of drug and/or alcohol use during pregnancy? |
|  |
| Child’s physical health and wellbeing |
|  |
| How does the child hold themselves and how do they move?(E.g. When they stand or walk, is it a smooth, well co-ordinated movement? Do they seem to have good core strength? Are their movements floppy or jerky? Does their body look as if it’s working as one fluid unit? Is it well synchronised? Do arms and legs work helpfully together? What is their head position like?) |
|  |
| Has the child had a neurodevelopmental assessment for ASC or ADHD? If so, what was the outcome? |
|  |

**Information about current difficulties and outcomes being sought**

|  |
| --- |
| What are the family asking for help with |
|  |
| What does the referrer think is required |
|  |
| What are the referrer’s desired outcomes of any interventions provided  |
|  |
| What are the parent’s desired outcomes of any interventions provided, and the child’s desired outcomes  |
|   |

**Referrer’s Name: Date:**