**Please note missing information will result in the referral being returned.**

**Name of Referrer: Date of Referral:**

**Name of Organisation (if relevant):**

**Address:**

**Contact Number:**

**Email address:**

**Relationship to Child:**

 **Is Parent / Child aware of referral?**

|  |
| --- |
| **Name of Service User: DOB: Gender:****Ethnicity: First language:****Address:** **Contact Number:** **Email:** **GP Name/Address:** **School Name/Address:** |

|  |  |  |
| --- | --- | --- |
| **Name of others living at the property** | **DOB** | **Relationship to client e.g. Parent/Sibling/Aunt**  |
|  |  |  |
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|  |  |  |

**Referral Reason (Please state if there is any broken equipment)**

|  |
| --- |
|  |

**Childs Diagnosis (if known)**: include patterns of movement as appropriate

Epilepsy? □Yes □ No Controlled by medication: □Yes □ No

Difficulty feeding due to poor posture / reflux □Yes □ No

Breathing difficulties? □Yes □ No

Poor trunk / head / neck control? □Yes □ No

Is the child Life limiting / palliative / end of life or terminal? (delete as appropriate)

**Previously known to Occupational Therapy.**

New to service? **□**Yes **□** No

Is the child hoisted? **□**Yes **□** No

If yes is the hoist free standing or fixed to the ceiling? (delete as appropriate)

If yes, are any of the slings ripped, frayed, damaged or instruction labels illegible?

(delete as appropriate)

Current weight: Current Height**:**

Has the property been previously adapted? **□**Yes **□** No

Does the child have any specialist postural seating at present? **□**Yes **□** No

Please state any other equipment already provided:

**Please email completed form to:**

CASS@birminghamchildrenstrust.co.uk

or post to:

C/O Birmingham Children’s Trust

Children’s Advice and Support Service

PO Box 16635

Birmingham B4 7DQ

0121 303 1888