**Children’s Therapy Services**

**Let’s Make Sense Together, Sensory Processing referral form.**

|  |
| --- |
| **FORM MUST BE COMPLETED IN FULL TO AID TRIAGE AND PRIORITISATION****Referrals only accepted from medical professions such as GP’s, Paediatricians, School Nurse, Other Therapy services** |
| Sensory processing is the ability to register, discriminate, adapt and respond physically and emotionally to sensory input, from our bodies and the environment around us.In those with sensory processing differences the brain is unable to clearly register and process this information which impacts on function and ability to participate in daily activities.  |
|  **Service Criteria*** Aged between 0 and 18 years.
* From a York, Selby, Scarborough, Whitby or Ryedale GP surgery
* Referral completed by a qualified health professional
* Parent/carer consented to referral
 | * Sensory processing differences are having a significant impact on physical wellbeing and functional skills in more than one environment.
* Parents and carers are aware there is the virtual component to our service that must be followed.
 |
| ***Please be aware we are unable to accept a referral where the concerns are related to Anxiety or behaviour and not physical functional activity. Parents and carers may still find out series of videos helpful so please to point them to our…..[healthier together webpage link]*** |
| **Child’s Details:** |
| Surname**:** | Forename/s: |
| Sex: Male  Female Prefer not to choose/say  | Date of Birth: |
| Ethnicity: | Address: |
| Parents/Carers name/s and relationship: | Telephone number: |
| Parents/Carers email: | Consent to contact via: Email  Text  |
| Diagnosis/current health concerns/medication: |
| Has the child/young person been seen by our service within the last 12 months? No  Yes Only re-refer a child who has a new functional difficulty |
| **NHS Number:** |  |
| **General Practitioner (GP):** |
| Initial | Surname | Surgery address: | Telephone No: |
| **School Details:** |
| School attended: | Year: | School Phone number: |
| School SENCo: | Does the child have an Education and Health care Plan? No  Yes  |
| **Referral Details:** |
| Referrer Name: | Professional Role: |
| Address: | Signature: |
| Date of referral: | Contact number: |
| ***Disclaimer – by signing this referral, you are agreeing that all the information contained is correct and completed by the referrer. Additional information from the family is acceptable if this is clearly stated.*** |

|  |
| --- |
| Does the child meet all the service criteria (please find listed above):  Yes Have parents/carers accessed the website and implemented strategies?  YesIf access to the website is not possible, please outline why below: |
| **Reason for Referral** |
| Describe the sensory differences and how they significantly affect day to day  function/activities (please be specific – which tasks are difficult, what did you observe?):What are the main areas of concern (sensory) to be addressed? |
|  Please provide evidence of the resources/strategies trialled prior to referral:  (this is stage one of our service and a listed criteria)  At home:  Education environment:  |
| **Safeguarding** |
| Is the family aware of the referral? |  |  |  |
| Looked after child? |  |  |  |
| Child with Additional Needs? |  |  |  |
| **Other Risk Factors:****Please note it is the responsibility of the refer to make appropriate referrals if immediate risk is identified** |
| **Any reasonable adjustments needed? e.g. accessible entrance? communication aids? Is an interpreter required?** |
| **Other Agencies/Professionals involved (please include if awaiting service input):** |

Please forward this referral form………