Children’s Therapy Services

Before completing this form please ensure you have accessed our training video on our website

Request for Support

Schools and other professionals can make a request for support to Childrens Therapy Services, the criteria for support is as follows:

* Children and young people aged 0-18 years, or 19 if still in full time education, that have a Poole, Bournemouth, or East Dorset GP.
* Children that are having difficulties with everyday tasks (for example dressing, eating, toileting, handwriting, washing, grooming, playing/leisure etc). These difficulties should be more so than is expected for their cognitive level, and/or they are not making progress with these activities.

 Exclusion criteria:

* Children who present with a primary mental health, emotional or behavioural difficulty
* Support for sensory processing can only be provided for children with a diagnosis of ASD or undergoing assessment for ASD.

If you have any questions regarding this request please contact us on cts.referrals@uhd.nhs.uk, a phone call can be arranged with you via email if required

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| **Request for Support**  |
| Child’s Name |  | Date of Birth |  |
| School |  | Address |  |
| Your name, job title and contact details |  | Parents contact details  |  |
| Any safeguarding issues:  | Other professionals involved:*Please consider making a paediatrician referral if appropriate.*  |
| Diagnosis or medical history:  |
| **Section 1**What is your reason for making this request? |
| Please describe the everyday activities the child is having difficulties with. How long has this been a problem? Where does this problem occur? Home v schoolWhat are the child’s thoughts on their difficulties?  |  |
| **Section 2**What has been tried already? |
| What has / has not worked at school and home?Why do you think strategies trialled have not worked? Has the child been referred to our team in the past? If yes, when and what was the outcome? e.g. learn 2 move, support in school, other agenciesIf the child has completed learn 2 move please provide ABC checklist scores  |  |
| **Section 3**What outcomes are you hoping to achieve? |
| What would you like the child to be able to do or achieve as a result of this request for support? What would the child like to achieve?  |  |
| Are parents and child aware and have they given consent for this request for support?  |  |
| Would it be beneficial for parents to have a phone call with a therapist before bringing the child to their first appointment? | Yes No |
| Date you completed this form  |  |

Please return this form via secure email to cts.referrals@uhd.nhs.uk

or via post to:

Children’s Therapy services

Child Development Centre

Poole Hospital

Longfleet Road

Poole Hospital NHS Foundation Trust

Dorset

BH15 2JB