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Schools Therapy Resource Pack

Section nine – How to refer

Single Point of Access

The Children's Therapy team can be contacted by telephone call to:

Single Point of Access (SPA):
0300 300 2019
Monday to Friday
8am to 6 pm

Email to: solentchildrenstherapyservice@solent.nhs.uk

Post to: Children's Therapy Service
Better Care Centre (Orchard Centre)
William Macleod Way
Southampton
Hampshire
SO16 4XE

All school referrals should be sent to our Children's Therapy Single Point of Access (SPA).
All referrals will need to have all of the following:

- ☑ **Integrated referral form**: The referral form can be found within this section and is available electronically from the website www.solent.nhs.uk/childrenstherapies.
- ☑ **Checklist appropriate to referral**
- ☑ **Evidence of strategies used from the schools pack, the period of time that these have been used for and the outcomes of that intervention**: see section 3 for suggested format

Early Years Motor Skills Checklist
For Year R referrals only

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All Sections Must be Completed and accompany the integrated referral form

Name of child: DOB:

Person completing this form:

Please attach copies of record of intervention form for Achieving Body Control (ABC) and FMS / Clever Hands programme.

N.B. referrals will not be accepted until at least one block of both programmes have been completed

Motor Skills

Please provide examples of the child's writing/drawing

	Yes/No	Comment
Reliably uses one hand as dominant		
Colours within boundary lines		
Can copy a vertical/horizontal cross +		
Can copy an oblique cross X		
Holds pencil/scissors using appropriate grasp		
Can cut along a straight line with accuracy		
Can draw a recognisable person		
Picks up and uses small objects efficiently (blocks, beads)		
Can fasten buttons		
Able to catch a large ball		
Able to catch a bean bag		
Able to kick a stationary ball		
Balances on one leg for 5 seconds		
Can jump two feet together		
Fluent movements when running		
Moves around avoiding objects in the playground		
Moves around avoiding objects classroom		

For children in year one onwards please complete this checklist for motor skill referrals and attach to the integrated referral form with evidence of strategies/programmes tried.

COORDINATION QUESTIONNAIRE (REVISED 2007)

	Year	Mon	Day
Today's Date:			
Child's Birth:			
Child's Age:			

Name of Child: _____

Person completing Questionnaire: _____

Relationship to child: _____

Most of the motor skills that this questionnaire asks about are things that your child does with his or her hands, or when moving.

A child's coordination may improve each year as they grow and develop. For this reason, it will be easier for you to answer the questions if you think about other children that you know who *are the same age as your child*.

Please compare the degree of coordination your child has with other children of the same age when answering the questions.

Circle the one number that best describes your child. If you change your answer and want to circle another number, please circle the correct response twice.

If you are unclear about the meaning of a question, or about how you would answer a question to best describe your child, please call _____ at _____ for assistance.

Not at all like your child	A bit like your child	Moderately like your child	Quite a bit like your child	Extremely like your child
1	2	3	4	5

1. Your child *throws a ball* in a controlled and accurate fashion.

   1 2 3 4 5

2. Your child *catches* a small *ball* (e.g., tennis ball size) thrown from a distance of 6 to 8 feet (1.8 to 2.4 meters).

   1 2 3 4 5

3. Your child *hits* an approaching *ball* or *birdie* with a bat or racquet accurately.

   1 2 3 4 5

4. Your child *jumps* easily *over* obstacles found in garden or play environment.

   1 2 3 4 5

5. Your child *runs* as fast and in a *similar* way to other children of the same gender and age.

   1 2 3 4 5

6. If your child has a *plan* to do a motor *activity*, he/she can organize his/her body to follow the plan and effectively complete the task (e.g., building a cardboard or cushion "fort," moving on playground equipment, building a house or a structure with blocks, or using craft materials).

   1 2 3 4 5 (OVER)

 www.dcdq.ca

	Not at all like your child 1	A bit like your child 2	Moderately like your child 3	Quite a bit like your child 4	Extremely like your child 5
7.	Your child's printing or *writing* or drawing in class is *fast* enough to keep up with the rest of the children in the class.				
	1	2	3	4	5
8.	Your child's printing or *writing* letters, numbers and words is *legible*, precise and accurate or, if your child is not yet printing, he or she *colors and draws* in a coordinated way and makes pictures that you can recognize.				
	1	2	3	4	5
9.	Your child uses appropriate *effort* or tension when printing or writing or drawing (no excessive *pressure* or tightness of grasp on the pencil, writing is not too heavy or dark, or too light).				
	1	2	3	4	5
10.	Your child *cuts* out pictures and *shapes* accurately and easily.				
	1	2	3	4	5
11.	Your child is interested in and *likes* participating in *sports or active* games requiring good motor skills.				
	1	2	3	4	5
12.	Your child learns *new motor tasks* (e.g., swimming, rollerblading) easily and does not require more practice or time than other children to achieve the same level of skill.				
	1	2	3	4	5
13.	Your child is *quick and competent* in tidying up, putting on shoes, tying shoes, dressing, etc.				
	1	2	3	4	5
14.	Your child would *never* be described as a *"bull in a china shop"* (that is, appears so clumsy that he or she might break fragile things in a small room).				
	1	2	3	4	5
15.	Your child does *not fatigue easily* or appear to slouch and "fall out" of the chair if required to sit for long periods.				
	1	2	3	4	5

Thank you.

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Children's Therapy Service Referral Form

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Please return the completed form to: Children's Therapy Service, 2nd Floor, Adelaide Health Centre, William Macleod Way, Millbrook, Southampton SO16 4XE
Email: solentchildrenstherapyservice@solent.nhs.uk

Service referred to:	
Speech & Language Therapy	☐
Occupational Therapy	☐
Physiotherapy	☐

Client details:		NHS No:
First Name	Surname Previous names:	Date of birth: Male ☐ / Female ☐
Address: Postcode:		
Name of parent/guardian		
First name	Surname	
Daytime tel:	Home tel:	Mobile tel:
Ethnicity:		
Languages spoken at home:	Interpreter/Signer required: Yes ☐ / No ☐ Language:	
GP name:	Health Visitor/School Nurse Name:	
Surgery:	Base address:	
Tel:	Tel:	
Preschool / School name:	Days/Times attended:	
Address: Postcode:	Tel:	
Transport difficulties: Yes ☐ / No ☐	Details:	

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Referral information *(Please attach appropriate supporting evidence from Early Years Developmental Checklist, Schools pack, Feeding Questionnaire or Child Monitoring tool as well as any audiology or recent paediatrician reports)*	
Diagnosis (if known):	Statemented: Yes ☐ / No ☐ Statement designation:
Are there any Safeguarding issues?	
Is the child a Looked After Child? Yes ☐ / No ☐	
Social services involvement: Yes ☐ / No ☐ Social worker's name: Contact number:	
Are there any concerns about; hearing? Yes ☐ / No ☐ vision? Yes ☐ / No ☐	Has hearing been tested? Yes ☐ / No ☐ Date:
Reasons for referral:	
What is the functional impact? Give details:	
What support has already been provided? Please attach supporting information ☐	
Has it made a difference? Yes ☐ / No ☐	
Other professionals/services currently involved (e.g. Paediatrician, Portage, Audiology, Educational Psychologist. Please provide names where known)	

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Referral and background information

Please complete as fully as possible at referral stage, to avoid the family having to repeat family history
Developmental and medical history information
Were there any complications in pregnancy or birth?

General health/Childhood illnesses					
Are the child's immunisations up to date? Yes ☐ / No ☐					
Does the child have any allergies? Yes ☐ / No ☐	If 'yes' please state:				
Is there any family history of medical diagnoses? (e.g. autism, specific learning difficulties, developmental delay)? Please give details:					
Current treatment/Medication:					
Has the child had any of the following (please circle)?:	Frequent colds	Frequent ear infections	Frequent chest infections	Tonsillitis	Asthma
Has the child had any visits to hospital?			Yes ☐ / No ☐		
If 'Yes' please give details:					

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Hearing/Vision	
Does anyone in the family have a hearing impairment/loss/deafness?	Yes ☐ / No ☐
Has the child had middle ear infections/glue ear?	Yes ☐ / No ☐
Does anyone in the family have visual impairment?	Yes ☐ / No ☐

Feeding	
Can the child eat foods that need chewing e.g. meat, sandwiches, raw fruit or vegetables?	Yes ☐ / No ☐
Did the child have any problems weaning/taking lumps?	Yes ☐ / No ☐
Do they use a bottle, beaker, inverted lid or open cup to drink?	
Has the child ever had fluid or food escape through their nose?	Yes ☐ / No ☐

Motor skills			
Does the child *(please also indicate from what age)*:			
Roll	Age:	Crawl	Age:
Sit	Age:	Walk	Age:
Run	Age:		
Do you have any concerns about their movements?		Yes ☐ / No ☐	
Does the child complain of pain?		Yes ☐ / No ☐	
Do you have concerns about the child's hand skills? (e.g. Handwriting/scissors/using construction toys/throwing and catching a ball)		Yes ☐ / No ☐ Please describe	

Personal care		
Is the child toilet trained?	Yes ☐ / No ☐	If yes, at what age?:
Can the child dress themselves? Manage buttons/shoelaces	Yes ☐ / No ☐ Yes ☐ / No ☐	If no, please describe difficulties
Can they use a knife and fork?	Yes ☐ / No ☐	If no, please describe difficulties

Emotional				
What time does the child...	Go to sleep:		Wake up:	
Does the child stay in their own bed?	Yes ☐ / No ☐			
Do they use a: *(please circle any that apply)*	Dummy	Bottle	Security blanket	Other comforter

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Play and attention	
What types of games/toys/activities does the child enjoy?	
Does the child like to play with others (adults or children)?	Yes ☐ / No ☐
Roughly how many hours of TV/DVD/Computer time a day does the child watch?	
How would you describe the child's attention span for:	
- Activities of their own choice:	
- Activities that the parent chooses:	

Speech and Language						
Is there a family history of speech and language difficulties? e.g. late talking, unclear talking, stammering (please give details of who and what)?						
If the family uses more than one language at home, when is each language spoken and to whom?						
Did the child babble as a baby?			Yes ☐ / No ☐			
At what age did the child:	Say their 1st word:		Begin to put 2 words together:		Talk in sentences:	
Does the child dribble excessively for their age?				Yes ☐ / No ☐		
Does the child have any problems with their teeth?				Yes ☐ / No ☐		
Does the child have any problems with their lip or tongue movements?				Yes ☐ / No ☐		

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Referrer details:	Date of referral:
Name of referrer *(please print name):*	
Profession *(e.g. Hospital/GP/HV/Preschool)*:	
Would you like a copy of the appointment date? Yes ☐ / No ☐	
Address:	
Tel:	**Signature:**

Parent / Guardian consent		
This referral has been discussed with me, and I agree to take my child to the clinic for assessment and ongoing therapy intervention as required, which may take place in school, clinic or nursery setting. I understand that if I do not attend the assessment, my child will be discharged and no further appointments will be offered. I am aware that for training purposes, a student may be present. I agree to the sharing of information with services relevant to my child's treatment / care		
Name of parent/guardian *(PRINT NAME)*:	**Signature:** **If unsigned, verbal consent given:** ☐	**Date:**
We constantly aim to improve our services and we value your feedback. Please tick box if you would be happy for us to contact you in the future ☐		

Therapist use only	
Signature:	Date:
Location:	

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Feeding Questionnaire

Please complete and attach to the Children's Therapy Service Referral Form	
Child's name:	NHS number:
Date of birth:	Age:
Name of referrer: Contact:	
Area of concern and reason for referral:	
Any recent changes in the child's ability to eat/drink? (e.g. increased gagging/coughing, not managing more complex food texture or not coping with usual textures or drinks, concern about deterioration of skills)	
Any recent signs of aspiration/choking? (Please describe i.e. coughing, gurgly voice, red face, feeling of food stuck/feeling of choking/rattly breathing sound only when eating or just after eating)	
General health (including any chest infections, respiratory difficulties e.g. asthma possible developmental problems, medical diagnosis)	
Any signs/diagnosis of reflux and/or vomiting?	
Is the child's weight stable? Have they lost or gained weight significantly in the last 2-4 months?	
Current feeding regime, including alternative feeding intake and quantity	

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Drinking:	Type of teat:
Quantity and type of fluids consumed:	
Describe seating used at meal times:	
Length of time taken to consume each different meal:	
Describe any signs of pain / discomfort:	
Any sensory issues/challenging behaviour during meals:	
Level of parental concern:	
Information regarding strategies already attempted, advice already provided and their effectiveness:	