Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

# PRIMARY CARE PAEDIATRIC OCCUPATIONAL THERAPY REFERRAL FORM

Primary Care Paediatric O.T.,
HSE South – Cork North/South Lee,
Block 34,
St. Finbarr's Hospital,
Douglas Road,
Cork
Tel: 021-4927850

**Office Use**:
Previous Waiting list Date _____ Previous Discharge Date_____

**Child's Name**: _____ **Date of Birth**: _____

**Child's Address**: _____

**Gender:** Male ☐ Female ☐ **Medical / LTI Card No**._____

**Diagnosis/Relevant Medical History**: _____

**Parents/Guardian**: _____

**Contact Numbers:** _____ **Email Address**: _____

**Language Spoken at Home:** _____

**Relevant Family Information**: _____

**Siblings**: _____

**Please detail below the reason for referring this child to Primary Care Paediatric Occupational Therapy Service**

Fine Motor: _____

Gross Motor: _____

Sensory Difficulties: _____

Self Care Skills: _____

Schooling Issues: _____

Handwriting: _____

Perceptual Skills: _____

Equipment Needs: _____

Other: _____

**Have you previously attended Primary Care Occupational Therapy?** **No** ☐ **Yes** ☐ Discharge date: _____

**What do you hope to achieve by this referral?**

_____

_____

**Education:**

Name of Preschool/School: _____ Contact Number: _____
Address: _____

Principal: _____ Class Teacher: _____ Class/Year: _____

Learning Support/Resource Teacher:_____ Hrs:____ SNA: Full Time ☐ art Time ☐ one ☐

**Other agencies involved & contact details:**

| | |
|---|---|
| G.P. | |
| Area Medical Officer (AMO) | |
| Paediatrician | |
| Psychology(Educational, Clinical) | |
| Speech & Language Therapist | |
| Physiotherapist | |
| Private Occupational Therapist | |
| Public Health Nurse | |
| Tusla (e.g. Social Work) | |
| Other Services (e.g. Cope, ASD, Enable Ireland, Brothers of Charity, CAMHs) | |
| Referred/waiting for other service input (e.g. ASD, CAMHS)? | |
| Referred/currently waiting for AON assessment? | |
| Other (e.g. COPE, CAMHs) | |

***Please attach all relevant reports***

**Referrer Details**

**Name:** _____ **Date:** _____

**Address:** _____

**Contact number:** _____ **Email address:** _____

**Parent/Guardian consent for referral:** Yes ☐ No ☐

**Parental/Guardian signature:** Mother: _____ Father: _____

**For Office Use Only**

Referral appropriate ☐ Referral inappropriate ☐ Questionnaires sent ☐

Letter sent to parents/guardians ☐ Letter sent to referrer ☐

Priority given: P1: ☐ P2: ☐ Reason: _____

Signed: _____ Date: _____

**Occupational Therapy Screening Notes:**

| Date | | Signed |
|---|---|---|
| | | |
| | | |
| | | |