**Occupational Therapy Referral Form**

**Richmond Pediatric Team**

Richmond Public Health

8100 Granville Avenue

Richmond, BC V6Y 3T6

Phone: (604) 233-3150 Fax: 604-233-3198

Email: [rhspeds@vch.ca](mailto:rhspeds@vch.ca)

***\** Please complete all areas on this form**

1. **General Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referral Date** | Child’s Last Name | | Child’s First Name | Child’s Preferred Name | |
| Personal Health Number | Date of Birth (dd/mmm/yyyy) | | Primary Language(s) | Interpreter needed? *(no cost)*  Yes  No | |
| Gender | Preferred Pronouns | | Preferred Phone Number | Alternate Phone Number | |
| Address (*including city and postal code*) | | | | | |
| □ Parent / □ Legal Guardian /□ Foster Parent (first and last name) | | | □ Parent / □ Legal Guardian / □ Foster Parent (first and last name) | | |
| Additional Phone Number(s) | | Preferred Pronouns | Additional Phone Number(s) | | Preferred Pronouns |
| Email | | Relationship to Child | Email | | Relationship to Child |

|  |  |
| --- | --- |
| School: | Grade: |
| Teacher | Resource Teacher: |
| Social Worker (if known): | Speech/Language Pathologist: |

*2.* **Specialists or Agencies Involved:**

Family Doctor:       Dr’s Phone:

Has       been seen by other service providers in the past 3 years? Yes  No

*If yes, please indicate which:*

Private Occupational Therapist:

Name/contact info:

BC Children’s Hospital /Sunny Hill:

Involved team or clinic:

Centre for Ability:

Discipline involved/date last seen:      \_\_\_\_\_\_\_\_\_\_\_\_\_

*3.* ***Pertinent Medical History: (including diagnosis, seizures, medications)***

4. ***Reason for referral to Richmond Pediatric Team Occupational Ther*apist**

Primary Occupational Therapy concern of the school:

Primary Occupational Therapy concern of the family:

How does the concern interfere with classroom activities?

     

What have you already tried in order to help the student with this concern?

*5.* ***Occupational Therapy – Areas of Concern:*** *Please check if child has difficulties with the following*:

**Fine Motor/Visual Processing: Self Care:**

printing/handwriting  toileting

pencil grasp  self-feeding

scissor skill  spatial orientation of written work

dressing

copying from blackboard

swallowing/choking (please describe):

Other/Additional comments:

**Equipment (student currently uses OR student needs)**

wheelchair

hand splints

toileting equipment

building accessibility

computer access (please describe):

adapted equipment (please describe):

Other/Additional Comments:

**Sensory** *If sensory concerns are the* ***primary*** *concern, please discuss with your District Support Team member before completing any Occupational Therapy Referral (including this form).*

If there are sensory concerns that ***impact on*** the Primary Occupational Therapy concern of the school (question 4), please provide further details:

*6.* ***School Performance Concerns:*** *Please check if the child has difficulties in the following areas:*

|  |  |  |
| --- | --- | --- |
| behaviour | learning new motor skills | hearing |
| attention | understanding new concepts | vision |
| ability to follow directions | general organizational skills | speech/language |

Describe:

Is there a marked difference between verbal and written ability?  Yes  No

Additional comments:

Is child currently performing to grade level in all areas of academic curriculum  Yes  No

If no, what accommodations or adaptations are being made?

Referral form completed by:       Role (i.e. EA, teacher) :

E-mail of referrer:       Date:

Parent/Guardian has been contacted and given verbal consent for the referral?  Yes  No

*You are welcome to send referrals via e-mail. Because referrals often contain personal/health/confidential information, we ask that you send the referral as a password-protected file. To encrypt, please open the referral as a Word document, go to File > Info > Protect Document > Encrypt with a Password. Please send the password in a separate email.*