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Child Development & Occupational Therapy

OCCUPATIONAL THERAPY CONFIDENTIAL REFERRAL FORM

Child & Family Information

Child's Name: .....Male: ❑ Female: ❑
Birth Date: ..... Diagnosis (if applicable): .....
Parent/Legal Guardian Name(s): ..... Relationship: .....
Street Address: .....
Post Box: ..... Town: ..... Postal Code: .....
Phone numbers: .....(home) ..... (work) .....(cell)
Email address: .....
Preferred method of contact: Home phone: ❑ Work phone: ❑ Cell: ❑ Email: ❑

Referral Information

Date of Referral: .....

What concerns regarding this child would you like addressed? .....
.....
.....
.....

What has been done so far to address these concerns? .....
.....
.....
.....
.....

Referral Information Continued

Is there anything else about the child that concerns you?

	No concern	Some concern	Great concern
Sensory:			
Hearing	❑	❑	❑
Vision	❑	❑	❑
Touch	❑	❑	❑
Oral	❑	❑	❑
Self regulation	❑	❑	❑
Social/Emotional:			
Interacting with peers	❑	❑	❑
Playing safely	❑	❑	❑
Behavior	❑	❑	❑
Self esteem	❑	❑	❑
Behavior	❑	❑	❑

	No concern	Some concern	Great concern
Physical Abilities:			
Gross motor coordination	❑	❑	❑
General fine motor control	❑	❑	❑
Cutting, coloring, printing	❑	❑	❑
Self help skills (e.g. toileting, dressing, eating).	❑	❑	❑
Communication:			
Understanding spoken messages	❑	❑	❑
Using words to communicate	❑	❑	❑
How clearly words are spoken	❑	❑	❑

Person Completing This Form

Name: ..... Contact phone: .....

Title/Agency (if relevant): .....

Email address: .....

Parent/Guardian Consent

I have read the information included in this referral and agree with the information provided. I agree to this referral being made, and to my child receiving Occupational Therapy services.

Name (please print): .....

Signature: ..... Date: .....