TRAFFORD COUNCIL

Pennine Care NHS
NHS Foundation Trust

Referral for Trafford Children's Therapy Service

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS
NOTE: Incomplete referrals cannot be processed and will be rejected.

Family Name		**Child's first name(s)**	
NHS Number:			
Gender	M F	**Date of birth**	
Address			
Postcode		**Telephone:** **Mobile:** **Email address**:	

Ethnicity — **If other please specify:**

☐ White British	☐ White Irish	☐ Any other White background
☐ Gypsy/Roma	☐ Traveller of Irish Heritage	☐ Black Caribbean
☐ Black African	☐ Any other Black background	☐ Indian
☐ Pakistani	☐ Bangladeshi	☐ Chinese
☐ Any other Asian background	☐ White & Black Caribbean	☐ Any other ethnic background
☐ White & Asian	☐ White & Black African	☐ Any other Mixed background
☐ Info not obtained	☐ Refused	

Child's first language		**Parent/Carer's first language**	
Is an interpreter required?	Yes No	Religion	
Trafford GP		**School/ Nursery**	

Who else is involved with the child?
Please attach any relevant forms, observations, programmes of work.

Educational Psychologist	☐	Teaching Assistant	☐	Clinical Psychologist	☐
Psychiatrist	☐	Paediatrician	☐	Orthopaedic Consultant	☐
Social Services	☐	Consultant (Other)	☐	Other (AHP)	☐

Name and telephone number of Social Worker _____

Others: _____

Stage of SEND Code of Practice: _____

Trafford Council and health services are integrated to improve outcomes for children, young people, their families and schools.

Visit us at www.penninecare.nhs.uk

POSITIVE ABOUT DISABLED PEOPLE

Reason(s) for referral
Please give specific details of the difficulties using extra page if necessary

Past Medical History – including allergy status

Current Investigations / Treatment

>X- rays **> Injection**

> Drugs **>Other**

Indicate Therapy Service required:

Physiotherapy □ **Occupational Therapy** □ **Orthotics / Hand Splinting** □

DCD/Motor Skills □ **Sensory** □

Consent:	Yes	No
I agree to this referral	□	□
I give permission for other professionals to be contacted about this referral. This includes school/nursery.	□	□
I give permission for the Therapist to leave text, or telephone messages regarding appointments.	□	□

Parent/Carer signature…… Date:

(BLOCK CAPITALS) ……

Referrer details (BLOCK CAPITALS):

Name		Role	
Address		Telephone	
Email			

I have discussed the referral with the parent/carer and have agreed to sign on their behalf:

REFERRER SIGNATURE:……Date:……
Please send completed forms to: