

# **Wirral Children's Occupational Therapy Service**

## **Referral for Sensory Motor Processing Difficulties**

Please complete all sections of the form. Failure to do so will result in the referral being returned to the referrer and will delay the assessment process.

Name: ..... DoB: .....

**Address.....** **Tel No.....**

**Email address of parent/guardian.....**

**Name of parent/guardian.....**

**School**.....

**GP.....** **Address.....**

Has the child been seen by an OT previously? YES / NO Approx date.....

Past/present medical History.....

**Any significant safeguarding history?**.....

Does the child have a developmental delay? YES / NO    Approx delay    1-2yrs    3-4 years    other

**Does the child have an Educational, Health and Care Plan (EHCP)?** **YES / NO**

Is the child at risk of seriously injuring self or others due to sensory / behavioural difficulties? E.g. biting, hitting, throwing furniture, exclusion from school      YES / NO

**Please give details (include where behaviours occur).**.....

**Does the sensory processing difficulties significantly interfere with academic achievement or activities of daily living?** **YES / NO**

**Does the child have motor skill difficulties?** **YES / NO**  
(if yes please refer through the DCD pathway)

Sensory system involved	Behaviours displayed	State what the child cannot do as a result of this difficulty
Touch		
Auditory		
Visual		
<b>Vestibular</b> (movement sense, balance, fear of heights, movement seeking eg. rocking, spinning, twirling,		
<b>Modulation</b> (attention, distractibility, sensory seeking behaviour, becomes overly excitable lethargic, emotional reactions, sensory avoiding behaviours)		

**Other agencies referred to or involved in assessing/treating the child's sensory difficulties:**

Physiotherapy       Speech and Language Therapy       Child & Family  
 Educational Psychologist      Other: .....

**Current diagnoses being considered**

DCD/Dyspraxia       ASD       ADHD       Developmental delay  
Other: .....

**Is the Parent/guardian aware of the referral to Occupational Therapy?      YES / NO**

**Name.....** **Signature.....**

**Designation.....** **Date.....**

**Please return the referral form to:** Children's Occupational Therapy Department  
Children's OT DCD Team  
Cherry Tree House, Clatterbridge Hospital  
Bebington, Wirral. CH63 4JY  
Direct Dial (Cherry Tree): 0151 482 7732  
Email: [wuth.sensorymotorteam@nhs.net](mailto:wuth.sensorymotorteam@nhs.net)