

For office use: Triaged by:

Action to be taken:



**Wirral University
Teaching Hospital**
NHS Foundation Trust

**Wirral Children’s Occupational Therapy DCD Team
Referral for Motor Co-ordination 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 assessment process.

Name..... **DoB**.....

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

Email address for parent/guardian.....

Name of parent/guardian.....

School.....

GP **Address**.....

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

Past Medical History.....

.....
.....

Any current safeguarding concerns? YES / NO **Details**

.....
.....

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

Does the child have learning difficulties? YES / NO

If learning difficulties are present, are the motor difficulties in excess of those usually expected for the child’s developmental level of functioning? YES / NO

Does the motor impairment significantly interfere with academic achievement or activities of daily living? YES / NO

From clinical observations, please comment on observations made relating to the following areas:

- Neuro examination.....
.....
- Balance.....
.....
- Pencil skills.....
.....
- Co-ordination.....
.....

Reported impact of coordination difficulties on the following functional skills (please circle)

Dressing Feeding Play/leisure Handwriting

Other agencies referred to or involved in assessing/treating the child's difficulties (please circle)

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

Current diagnoses being considered (please circle)

ASD DCD/dyspraxia ADHD SpLD Hypermobility
Developmental delay Other.....

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

- I can confirm that a neurological examination did not reveal any evidence of neurological deficit
- I can confirm that I will be responsible for providing the diagnosis following assessment

Name..... Signature.....

Designation..... Date.....

**Please return the referral form to: Children's Occupational Therapy DCD Team
Cherry Tree House, Clatterbridge Hospital
Bebington, Wirral. CH63 4JY**

Telephone (Cherry Tree): 0151 482 7732 Email:-wuth.childrensotdcdteam@nhs.net