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| **Occupational Therapy Referral Form** |

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| **Your personal details**  |
| Title |  | Forename |  | Surname |  |
| The name you would like to be referred to as: |  | DOB |  |
| NHS ID |  | Unknown [ ]  | Gender | Male [ ]  Female [ ] Transgender [ ]  Other [ ]  |
| Present address/location: |  | Permanent address (if different): |  |
|  |  |
| Post code |  | Post code |  |
| Telephone number |  | Telephone number |  |
| Resident of(name Borough/Shire/Council) |  |
| Your email address |  | Your next of kin (or friend/appropriate person) email address |  |
| Referrer’s email address (if relevant) |  |
| Occupation |  |
| Preferred language |  | Interpreter needed | Yes [ ]  No [ ]  |
| Other communication needs | Yes [ ]  No [ ] If ‘yes’ please provide details e.g.an induction loop |  |
| **Your care and support needs** |
| Please tick the care needs that affect you  | None | [ ]  | Speech/language | ☐ | Physical health | ☐ |
| Sensory impairment | [ ]  | Mobility | ☐ | Mental health | ☐ |
| Social needs | ☐ | Alcohol/substance use | ☐ | Learning disability | ☐ |
| Older person | ☐ |  |
| *Please provide details here:* |
| Please tell us below about your difficulty |
|  |
| Please tell us below how your difficulty affects your life |
|  |
| Please tell us below about any changes or life events that may have contributed to your difficulty |
|  |
| Please tell us below what you think would help with your difficulty |
|  |
| Please tell us what difficulty your relative or friend has noticed you as having  |
|  |
|  Please tell us below about anything else that is affecting your health and wellbeing |
|  |
| Please tell us about any services you are using to help with your difficulty  |
|  |
| **Accommodation details** |
| Please tick the accommodation you live in | House  | [ ]  | Registered care  | [ ]  |  |
| Flat/bedsit  | [ ]  | Supported Housing | [ ]  | Bed & Breakfast | [ ]  |
| Other | [ ]  | If ‘Other’ please provide details: |
| Please tick who owns your property | Council | [ ]  | Home owner | [ ]  |  |
| Private rented | [ ]  | With family | [ ]  | Housing association | [ ]  |
| Other | [ ] If ‘Other’ provide details: |
| Do you live alone? | Yes [ ]  No [ ]  | How many people live in your household? |  |
| Do you have any dependents? *(if yes please tell us how many dependants (e.g. sister, child) you have and whether you are the main carer)* | Yes [ ]  No [ ]  |
|  |
| Do you have any pets? | Yes [ ]  No [ ]  |
|  |
| Please tell how us how you enter your property (e.g. stairs, lift) |
|  |
| Please tell us who holds your keys other than yourself |
|  |
| Key safe available |  Yes [ ]  No [ ]  |
| **The people that support you** |
| ***Main carer (if applicable)*** |
| Name |  | Relationship |  |
| Address |  |
| Email |  | Telephone |  |
| ***Family (If different from above)*** |
| Name |  | Relationship |  |
| Address |  |
| Email |  | Telephone |  |
| ***GP*** |
| Name |  | Telephone |  |
| Address |  |
| Email |  | Fax |  |
| ***Hospital Consultant (if applicable)*** |
| Name |  | Telephone |  |
| Address |  |
| Email |  | Fax |  |
| ***Other professionals (if applicable)*** |
| Name |  | Telephone |  |
| Address |  |
| Email |  | Fax |  |
|  |
| **Signature**  |
| Do you consent to sharing information about you with relevant professionals | Yes [ ]  Yes: with limitations [ ]  No [ ]  |
| Your signature |  | Date |  |
|  |

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| **MONITORING FORM** |
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| **Age** |
| [ ]  Under 16[ ]  16-17[ ]  18-24 | [ ]  25-34[ ]  35-44[ ]  45-54 | [ ]  55-64[ ]  65-74[ ]  75-84 | [ ]  85-94[ ]  95+[ ]  Prefer not to say |
| **Disability and health** |
| Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? | [ ]  Yes, limited a little [ ]  Yes, limited a lot  | [ ]  No, not limited |
| Please tick a box or boxes below which best describes your impairment(s): |
| [x]  | **Hearing / Vision** (e.g. deaf, partially deaf or hard of hearing; blind or partial sight.) |
| [x]  | **Physical / Mobility** (e.g. wheelchair user, arthritis, multiple sclerosis etc) |
| [x]  | **Mental health** (lasting more than a year. e.g. severe depression, schizophrenia etc) |
| [ ]  | **Learning disability**  |
| [ ]  | **Memory problems** (e.g. alzheimer’s etc) |
| [ ]  | **Prefer not to say** |
| If you wish to tell us about your impairment, please do so here: |  |
| **Ethnic background** |
| **White or White British** |
| [ ]  British[ ]  English | [ ]  Scottish[ ]  Welsh | [ ]  Northern Irish[ ]  Irish | [ ]  Gypsy, Roma or Irish Traveller [ ]  Other European |
| [ ]  Other White (please specify if you wish):  |
| **[ ] Black or Black British** |
| [ ]  Black British[ ]  Caribbean  | [ ]  Nigerian[ ]  Ghanaian | [ ]  Sierra Leonean[ ]  Somali | [ ]  Other African  |
| Other Black (please specify if you wish):  |
| **Asian or Asian British** |
| [ ]  Asian British[ ]  Indian | [ ]  Bengali [ ]  Chinese | [ ]  Pakistani[ ]  Vietnamese | [ ]  Filipino |
| Any other Asian (please specify if you wish): |
| **Mixed Background** |
| [ ]  White and Black Caribbean | [ ]  White and Black African | [ ]  White and Asian  |
| [ ]  Other mixed background (please specify if you wish): **Continued on next page** |
| **Other Ethnicities** |
| [ ]  Arab [ ]  Latin American (please specify if you wish):[ ]  Any other ethnicity (please specify if you wish): |
| [ ]  Prefer not to say |
| **Preferred language** |
| [ ]  English | [ ]  Other (please specify if you wish): |
| **Religion or belief** |
| [ ]  Christian[ ]  Sikh | [ ]  Hindu[ ]  Muslim | [ ]  Jewish[ ]  Buddhist | [ ]  No religion[ ]  Prefer not to say |
| [ ]  Other religion or belief (please specify if you wish):  |
| **Marriage or civil partnership status** |
| [ ]  Married[ ]  Divorced[ ]  Widowed | [ ]  Registered in a civil partnership[ ]  Separated[ ]  Surviving member of a civil partnership | [ ]  Formerly in a civil partnership which is now legally dissolved[ ]  Never married or never in a civil partnership  |
| **Sex** |
| [ ]  Male | [ ]  Female | [ ]  Transgender |
| [ ]  Other gender identity (Please specify if you wish):  | [ ]  Prefer not to say |
| **Gender and gender identity** |
| Is your gender the same as the gender you were assigned at birth? | [ ]  Yes [ ]  No [ ]  Prefer not to say |
| **Pregnancy or maternity** (Tick here ‘[ ] ’ if not relevant) |
| Are you currently pregnant and / or on maternity leave? | [ ]  Yes [ ]  No [ ]  Prefer not to say |
| **Sexual orientation** |
| [ ]  Heterosexual/straight[ ]  Lesbian/Gay woman | [ ]  Gay man[ ]  Bi-sexual | [ ]  Prefer not to say |
| If you prefer to describe your sexual orientation differently please describe it here:  |

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| **What to do next…** |
|  |
| **Please email this referral form to:** Occupational Therapy Helpdesk Email: OccupationalTherapyHelpdesk@southwark.gov.ukTelephone number: 0207 525 3962 |