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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** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **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): | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Hearing / Vision** (e.g. deaf, partially deaf or hard of hearing; blind or partial sight.) | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Physical / Mobility** (e.g. wheelchair user, arthritis, multiple sclerosis etc) | | | | | | | | | | | | | | | | | | | | | |
|  | | | **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.uk](mailto:OccupationalTherapyHelpdesk@southwark.gov.uk)  Telephone number: 0207 525 3962 |