OCCUPATIONAL THERAPY REFERRAL FORM
RICHMOND PEDIATRIC TEAM

Richmond Public Health
8100 Granville Avenue
Richmond, BC V6Y 3T6
Phone: (604) 233-3150 Fax: 604-233-3198
Email: rhspeds@vch.ca

*** Please complete all areas on this form**

1. **General Information:**

Student's Name: _____ M ☐ F ☐
Last Name First Name

Date of Birth: _____ Personal Health Number (PHN) _____

Parents / Guardian Names: _____

Address: _____

Phone Number (Home): _____ (Work): _____

School: _____ Grade: _____

Teacher _____ Resource Teacher: _____

Social Worker (if known) _____ Speech/Language Pathologist _____

Main Language: _____ Is English Understood at home? Yes ☐ No ☐

2. **Specialists or Agencies Involved:**

Family Doctor: _____ Dr's Phone: _____

Has been seen by other service providers in the past 3 years? Yes ☐ No ☐

If yes, please indicate which:

☐ Private Occupational Therapist:

Name/contact info: _____

_____

☐ BC Children's Hospital /Sunny Hill:

Involved team or clinic: _____

_____

☐ Centre for Ability:

Discipline involved/date last seen: _____

_____

3. ***Pertinent Medical History: (including diagnosis, seizures, medications)***

4. ***Reason for referral to Richmond Pediatric Team Occupational Therapist***

Primary Occupational Therapy concern of the school:

Primary Occupational Therapy concern of the family:

How does the concern interfere with classroom activities?

What have you already tried in order to help the student with this concern?

5. ***Occupational Therapy – Areas of Concern:*** *Please check if child has difficulties with the following*:

Fine Motor/Visual Processing:

- ☐ printing/handwriting
- ☐ pencil grasp
- ☐ scissor skill
- ☐ dressing
- ☐ copying from blackboard
- ☐ swallowing/choking (please describe):

Self Care:

- ☐ toileting
- ☐ self-feeding
- ☐ spatial orientation of written work

Other/Additional comments:

Equipment (student currently uses OR student needs)

- ☐ wheelchair
- ☐ hand splints
- ☐ toileting equipment
- ☐ building accessibility
- ☐ computer access (please describe): _____
- ☐ adapted equipment (please describe): _____

Other/Additional Comments: _____

Sensory *If sensory concerns are the **primary** concern, please discuss with your District Support Team member before completing any Occupational Therapy Referral (including this form).*

If there are sensory concerns that ***impact on*** the Primary Occupational Therapy concern of the school (question 4), please provide further details:

_____

_____

6. ***School Performance Concerns:*** *Please check if the child has difficulties in the following areas:*

☐ behaviour	☐ learning new motor skills	☐ hearing
☐ attention	☐ understanding new concepts	☐ vision
☐ ability to follow directions	☐ general organizational skills	☐ speech/language

Describe:

_____

_____

Is there a marked difference between verbal and written ability? ☐ Yes ☐ No

Additional comments: _____

_____

Is child currently performing to grade level in all areas of academic curriculum ☐ Yes ☐ No

If no, what accommodations or adaptations are being made?

_____

_____

_____

Referral form completed by: _____ Role (i.e. EA, teacher) : _____

E-mail of referrer: _____ Date: _____

Parent/Guardian has been contacted and given verbal consent for the referral? ☐ Yes ☐ No

You are welcome to send referrals via e-mail. Because referrals often contain personal/health/confidential information, we ask that you send the referral as a password-protected file. To encrypt, please open the referral as a Word document, go to File > Info > Protect Document > Encrypt with a Password. Please send the password in a separate email.