Tasneem Arend
Occupational Therapist

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Occupational Therapy Referral Form

Private and Confidential

Child's full name: _____
Date of Birth: _____
Diagnosis: _____
Gender: _____
School: _____
Grade: _____

	Parent	Teacher/ Tutor (optional)
Full name		
Contact number		
Email Address		

Reason for Referral:	
How does this impact his/her daily activities?	
Areas impacted	☐ Personal care (feeding, toileting, dressing, hygiene, managing personal belongings, personal organization) ☐ Student role (E.g. following rules & routines, safety awareness, respecting the space/time/materials of others, staying seated, requesting help, making needs/wishes known social awareness, building/maintaining relationships) ☐ Learning/ processing skills (following demonstrations, copying models, carrying out verbal directions, attending to instruction, using classroom tools, managing materials, completing assignments) ☐ Play (turn-taking, imaginative play, sharing materials, exploring new play ideas/opportunities) ☐ Community Integration/Work (fieldtrips, school-related vocational training) ☐ Graphic communication (handwriting, keyboarding, drawing, art production) ☐ Interpersonal relations/ skills (communication, building & maintaining relationships, self-expression)

Brief medical history	

Other Health Professionals (HP) seen	Year Seen	Reason why the HP saw the client	Treatment Given	Currently still seeing client (Yes/ No)

Parent Signature:_____

Date of Referral: _____