PEDIATRIC OCCUPATIONAL THERAPY REFERRAL FORM

Sensation Station
501 Centerville Rd
Warwick, RI 02886
P: 401-732-5100
F: 203-286-1688

Sensation Station
1101 Noank Ledyard RD
Mystic, CT 06355
P: 917-279-0906
F: 203-286-1688

Sensation Station
2470 Boston Post Rd
Guilford, CT 06437
P: 203-458-1000
F: 203-286-1688

Please visit us at: Sensationstation.net

Please complete **ALL** sections and return to the Pediatric Occupational Therapy office at the above address. Referrals will not be accepted without parental consent. Incomplete referrals will be returned.

CHILD'S DETAILS

Child's Surname: ______________________ Date of Birth: ______________
Child's First Name: ____________________ Boy ☐ Girl ☐
Address: ____
____________________________ Full Postcode: ______________
Telephone Number (home): ______________ (Other): ______________
Names of Parents/Caregivers: ______________________________
Permission obtained from Parents/Caregivers: YES / NO Date Obtained: _____ / _____ / _____
Family's preferred language: ____________________ Interpreter Required: YES / NO
Pediatrician's Name, Address and Telephone Number: ______________________
____

EDUCATIONAL DETAILS

School / Nursery (Name and Address): ______________________________
____________________________ Telephone Number: ______________
Class / Nursery Teacher: ______________ Days attending Nursery: ______________
Current Statement of Special Educational Needs? YES / NO

MEDICAL HISTORY

Medical Diagnosis: ____
Significant Medical History: ____________________________________
____
Please identify all professionals involved with the child (e.g.: Psychologist, Home Based Therapy Services (HBTS) , Pediatrician, Physical/Speech & Language Therapist): ______________
____

REASON FOR REFERRAL

Briefly, describe the reason for referring to occupational therapy: ______________________
____
Physician: ____________________ Signature:______________________ Date: ____________