WESTERN ISLES NHS BOARD
OCCUPATIONAL THERAPY REFERRAL

To enable your referral to the Occupational Therapy Service to be prioritised according to identified risk, it is important that as much information as possible is provided.

Client details	
CHI:- **Full Name:-** **Address:-** **D.O.B.:-** **Tel. Number:-** **Mobile:-** **Email:-** **Preferred method & time for contact:** **Contact Person [if different]:-** **Contact Details:-** **Relationship to Client:-**	**Lives Alone:-** Yes □ No □ **G.P. Name :-** **G.P. Practice :-** **G.P. Tel. Number:-** **If Veteran, is condition as a result of active service:-** Yes □ No □ **Does client have** :a power of attorney □ Guardianship □ Compulsory Treatment Order □ Care Program Approach □

Has the client consented to this referral being made? : - Yes □ No □

REFERRER (if different from above)

Name:	Phone Number:
Address:	Relationship to client:
Signature:	Date of referral:

Current medical/ Psychiatric diagnosis; relevant investigations, medication, known allergies, contra-indications.	
Reason for referral to Occupational Therapy Services? In what way do you think OT can help? When did this problem start (date) and how often does it happen?	
Relevant past medical/ psychiatric history	
Any known risks e.g. recent falls, pain, unable to sleep due to condition, neglect, self harm, substance misuse, aggression,	
Is client an HHP Tenant? Yes □ No □	
Has equipment been supplied by Occupational Therapy Service, please list items below:	

Describe any difficulties with everyday activities:
Personal Care (e.g. dressing, toileting, bathing, feeding):
Functional Mobility (e.g. indoors, outdoors, getting on/off bed/ toilet/ chair/ getting in/out of bath/ shower): Is the bedroom/ bathroom located upstairs: Yes/ No/ Both - Please specify:
Work (e.g. remaining in work/ returning to work):
House hold management (e.g. cleaning, laundry, cooking, caring for others):
Play/ school:
Quiet recreation (e.g. hobbies, crafts, reading)
Active recreation (e.g. sports, outings, travel, physical activity)
Socialisation (e.g. visiting, phone calls, correspondence)
Is help received from any of the services (Homecare, Community Nurse, Day Centre, Other) **please specify frequency:**
What help is provided by carer (spouse, relative, friend, etc)**?**

Any other information:-	
Further help and information:	
OT service Lewis & Harris Western Isles Hospital MacAulay Rd Stornoway HS1 2AF Tel. 01851708287	OT service Uist & Barra Council Office Balivanich Benbecula HS7 5LA Tel. 01870 604984

For Office Use Only

NFA	Date:

Speciality	**Previously known to service**			**Referral received**	**PRIORITY**		**allocated to**	
					O.T.	**O.T.A.**		
	ALLOC. TO	**N.F.A.**	**Priority**	**DATE**			**INITIALS**	**DATE**