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.** <https://www.wihb.scot.nhs.uk/our-services/allied-health-professionals/occupational-therapy-and-community-equipment/>

**This referral can be emailed to:** [**wi.otwesternisles@nhs.scot**](mailto:wi.otwesternisles@nhs.scot)

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| **Client details** | |
| **Has the client consented to this referral being made?** : - Yes No**CHI:-**  **D.O.B.:-** **Full Name:-** **Address:-**  **Tel. Number:-**  **Mobile:-**  **Email:-**  **Preferred method & time for contact:** | **Lives Alone:-** Yes No  **Date of referral:**  **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 **Contact Person [if different]:-** **Relationship to Client:-**  **Contact Details:-** |

**Date of Referral:**

**REFERRER (if not self referral)**

|  |  |  |
| --- | --- | --- |
| Name: | Phone Number: | Relationship to client: |

**Referral completed by**

|  |  |
| --- | --- |
| **Name:** | **Phone number/ email:** |

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| **Diagnosed Medical/ Mental Health conditions; relevant investigations and medication.** | | |
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| **What is the reason for referral to Occupational Therapy Services and in what way do you think OT can help? When did this problem start (date) and how often does it happen?** | | |
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| **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 | | |
| **Difficulties with everyday activities describe below:** | | |
| **Personal Care** - this includes dressing, toileting, bathing, use of cutlery): | | |
| **Functional Mobility-** this includes getting on/off bed/ toilet/ chair/ getting in/out of bath/ shower, difficulty with steps/ stairs:  Is the bedroom located upstairs: Yes/ No  Is there a room that can be used as a bedroom downstairs: Yes/ No - Please specify:  Is the bathroom located upstairs: Yes/ No/ Both - Please specify: | | |
| **School/ Work** (e.g. remaining in work/ returning to work): | | |
| **House hold management** (e.g. cleaning, laundry, cooking, caring for others): | | |
| **What help is provided by carer** (spouse, relative, friend, etc) **or other services** (Homecare, Community Nurse, Day Centre, Other) **please specify frequency:** | | |
| **Any other difficulties or information: -** e.g. visiting, phone calls, correspondence, sports, outings, physical activity, hobbies. | | |
| **This referral can be emailed to:** [**wi.otwesternisles@nhs.scot**](mailto:wi.otwesternisles@nhs.scot) | | |
| **This referral can be posted to:** | | |
| OT service Lewis & Harris  Comhairle nan Eileen Siar  Sandwick Road  Stornoway  Isle of Lewis  HS1 2XF  Tel. 01851 822847 | OT service Uist & Barra  Council Office  Balivanich  Benbecula  HS7 5LA  Tel. 01870 604984 | |