**School Questionnaire for Children’s Community Occupational Therapy Service**

Please complete this questionnaire and return to coch.paediatricotquestionnaires@nhs.net The named child has been referred for an Occupational Therapy assessment. If you require support to complete this questionnaire, please contact 01244 363260. Please answer these questions in as much detail as possible to enable the Occupational Therapist to fully understand your child’s needs.

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| **Childs First Name:** | **Childs Surname:** |
|  |  |
| **Childs DOB:** | **Childs Age:** |
|  |  |
| **Person Completing Questionnaire:** | **Person Completing Questionnaires Role:**  |
|  |  |
| **School:** |
|  |
| **School Address:** |
|  |
| **School Contact Number:** |
|  |
| **Head Teacher:** |
|  |
| **Class Teacher:** |
|  |
| **1:1, TA/ LSA (if applicable):** |
|  |
| **Children’s Year at School (e.g. reception, year 7):**  |
|  |

|  |  |
| --- | --- |
|  | **Y/N** |
| **Does this child have a statement of special educational needs?** |  |
| **Is this Child being assessed for a statement of special educational needs?** |  |
| **Is this child on the Code of Practice at school?** (If ‘yes’ please give details of stage) |  |
|  |
| **Does the child receive any extra support at school?** (If ‘yes’ please give details) |  |
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| **Has an educational psychologist or advisory teacher seen this child?** (If ‘yes’ please provide name(s) and attach copy of report) |  |
|  |
| **Has a speech and language therapist seen this child?** (If ‘yes’ please provide name(s) and attach copy of report) |  |
|  |

Occupational therapists (OT’s)help children to access and manage self-care, school and home-based activities and play and leisure as independently as possible. This may be done by adapting the task or environment or by using specific activities to improve difficulties. Occupational therapists may give advice to parents and teachers so that they can help children to achieve independence.

Examples of areas where they can help:

* + Providing equipment to enable independent mobility, sitting, bathing and accessing school activities.
	+ Providing recommendations for activities to be done throughout the day to maintain attention and alertness.
	+ Providing advice on the best way to learn and improve in activities such as writing, dressing, using a knife and fork and riding a bike.

Knowing this, please complete the below by providing details of any areas where the named child is having difficulties that would benefit from the help of an Occupational Therapist.

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| 1. **Self-Care**
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| **Dressing** |
| (e.g. difficulties with changing for PE, buttons/zips/tying shoelaces, does not tolerate being dressed/certain textures of clothes) |
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| **Toileting** |
| (e.g. unable to sit upright on potty, difficulty getting on and off toilet, difficulty wiping) |
|   |
|  **Eating and Drinking**  |
| (e.g. difficulties using cutlery, opening packets, gets very messy when eating, seating problems, only eats certain foods) |
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| **Other** |
| (any other personal care issues you can think of) |
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| **B) Productive Activities** |
| **Moving Around** |
| (e.g. walking, running, getting into vehicles, opening doors, carrying things, using stairs) |
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| **School or Pre-school Activities**  |
| (e.g. access to the building, getting around the classroom, problems with classroom seating, behavioural issues, difficulty concentrating, difficulties in certain lessons or activities-reading/writing/P.E.) |
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| 1. **School Performance Skills**
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| **Handwriting and Pencil skills** |
| (e.g. difficulties with colouring, writing name, pencil grip, legibility, letter formation, letter sizing, alignment of writing on the page, copying from the white board, writing speed.) |
|  |
| **Preferred Hand** |
| Left  |  | Right  |  | Swaps |  |

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| **School Performance Skills** |
| (e.g. difficulties with reading, maths/numeracy, spelling, understanding language, cutting with scissors, finding way around school, speech, attention/concentration and following instructions.) |
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| **Play and Leisure**  |
| (e.g. difficulties with riding a bike, swimming, playing with friends, following rules, making friends, safety in the playground, confidence and self esteem.) |
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| **Movement and Balance**  |
| (e.g. difficulties with PE skills, walking, running, jumping, hopping, playing ball games, going upstairs/downstairs, walking on uneven surfaces and climbing.) |
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| **Activity** | **Skill Level compared to peers (x)** | **Estimated age level** |
|  | Below | Equal | Above |  |
| **Reading** |  |  |  |  |
|  |  |  |  |  |
| **Maths/ Numbers** |  |  |  |  |
|  |  |  |  |  |
| **Spelling**  |  |  |  |  |
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| **Additional Information:** |
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| **Signature** | **Designation** | **Date** |
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