**ADDITIONAL INFORMATION TO BE COMPLETED FOR ALL REQUESTS FOR OCCUPATIONAL THERAPY SENSORY PROCESSING ASSESSMENT:**

|  |  |  |
| --- | --- | --- |
| Child’s Name: | Date of birth: | NHS number: |
| **Please indicate the difficulties the child is facing: *(Please complete with parents/guardians)*****Using the table below please indicate if any of these are true for the child by ticking ✓ the relevant boxes:**

|  |  |  |  |
| --- | --- | --- | --- |
| Avoids being touched by others |  | Enjoys loud noises/music/environments |  |
| Becomes distressed or agitated if others are close |  | Becomes distressed by sudden or loud noise |  |
| Enjoys hugs/cuddles & seeks touch |  | Struggles with quiet noise such as fans/computer noise |  |
| Irritated by certain textures/clothing etc |  | Likes to put objects in mouth |  |
| Dislikes hair washed/cut |  | Chews or sucks clothing |  |
| Dislikes brushing teeth |  | Seeks movement activity |  |
| Dislikes nails being cut |  | Seeks climbing activity |  |
| Will only eat certain textures of food |  | Gets car sick |  |
| Dislikes certain smells (finds the intense) |  | Rocks/spins/swings |  |
| Unable to recognise strong smells that other can |  | Get dizzy easily |  |
| Becomes distressed in busy/loud environments |  | Finds it difficult to work/play in groups of people |  |

* **Please describe any other difficulties not listed above:**
* **Please describe any coping strategies the child/family/school already have in place:**
* **Please describe how these difficulties are affecting the child’s daily function:**
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| Please make sure all parts of the form are completed. This form must be accompanied by the Integrated Children’s Therapy referral form.**Decisions regarding the acceptance of referrals are based on the information supplied.** |