School Age Sensory Occupational Therapy (OT)
Functional Questionnaire Skills – To be completed by Home and School
Integrated Community Paediatric Services

Personal Details:			
Child's Name:		**D.O.B:**	
Address:		**NHS No:**	

Please complete this questionnaire **IN FULL** to help us assess your child's needs. It is beneficial for parents/carers & school to complete the form together. If your child does not attend an education setting we ask parents to complete as much of the form as possible.

Forms must be submitted to the Paediatric Occupational Therapy Service within 2 weeks of the date sent. Without this completed form **we are unable to offer an appointment** and your child will be discharged from this service.

If you have any difficulties completing this form, please contact the Paediatric Occupational Therapy team.

Contact Details:		
Parents Name:	**Address:** *(if different from above)*	**Telephone number:**
		Email Address:

Please tick to confirm parent completing this form will share correspondence with anyone else who holds Parental Responsibility (PR) for the child. ☐

If not, please provide contact of those with PR to enable us to inform them of this referral. This should include any parent with PR, whether or not they live within the home or have regular contact with the child.

Name and contact details:

If there are any legal reasons or safeguarding concerns that means information should not be shared, please add details below:

For legal definition see: ***Parental rights and responsibilities: Who has parental responsibility - GOV.UK***

Consent: *To be completed by parents/guardian*			
If accepted to the School Aged Sensory team, I give consent for my child to be assessed by the Occupational Therapy team	Yes ☐ No ☐		
I give consent for the School Aged Sensory team to share information relating to your child's assessment with relevant services, such as education teams, local authorities and health clinicians	Yes ☐ No ☐		
I give consent for communication via email (If this is a shared email address, I understand those sharing the account may be able to access information about my child)	Yes ☐ No ☐		
I give consent for communication by SMS	Yes ☐ No ☐		
My preferred communication method is	SMS ☐ Email ☐ Post ☐		
Signed by:		**Date:**	

Education Contact Details:			
School Name:		**School year:**	
School telephone number:		**SENCO Name:**	
Type of provision:	☐ Mainstream ☐ Specialist Unit ☐ Special School ☐ Alternative Provision	**SENCO email address:**	**Email address will be shared with parents in email correspondence*

Background Information: *To be completed by parents and school team to build a picture of your child's overall needs in different settings*			
Family Circumstances: *Who does your child live with and/or stay with. Include siblings, shared childcare etc*			
Medical History: *Does your child have any diagnosis or are they waiting for diagnostic assessment?*			
Professionals Support: *List other professionals or agencies providing support to your child and family for example, Paediatrician, Social workers, Specialist Educational Support. (Please add name and role)*			
Birth/Pregnancy history: *Were there any complications, hospital admissions?*			
Developmental Milestones: *Please tick if your child achieved each developmental milestone and where possible note at what age***:**	**Milestone**	**Achieved/Age**	**Comments**
	Rolled		
	Sat (unsupported)		
	Crawled		
	Walked		
	Fed Self with Spoon		
	Toilet Trained		

	Cut own food		
	Writes name		
	Pedal bike with stabilisers		
	Dress independently		
	Ride bike without stabilisers		
Life Experiences: *Has your child experienced anything frightening or traumatic?*			
Communication needs at home: *Does your child have any difficulties communicating? Do they use PECs, visual support, easy read documents, sign language, Makaton to help them communicate?*			
School Attendance: *Does your child regularly attend school. Have there been any exclusions? What is felt to be the barrier to school attendance?*			
Learning Level: *Is your child achieving to expected levels? In which subjects? Do they have known learning difficulties or disability? Do they have potential to achieve more but other barriers prevent them?*			
Additional Educational Support Offered: *Does the young person have 1:1 support, nurture access, specific interventions, part time timetable, alternative provision, EHCP?*			

Current Abilities in Daily Living Tasks (to be completed by school and home together):
Please provide details about the young person's strengths and difficulties in the following areas of daily living tasks.

SELFCARE

Does the young person show any of these behaviours during SELFCARE activities? *(please tick)*

☐ Has strong reaction to touch or tactile sensations i.e. washing face, hair washing, drying, cutting nails, brushing teeth	☐ Seeks out sensations such as running water, making sounds, pouring shampoo touch by rubbing flannel/towel repeatedly over body
☐ Distracted by objects or sounds in room	☐ Difficulties adjusting or co-ordinating body position to achieve task
☐ Dislikes strong flavours or smells such as shower gels/shampoos/toothpaste	☐ Eats soaps/shower gels

Please describe any other strengths or difficulties the young person has with **SELFCARE** activities:

Please tick how often the above behaviours impact the young person's ability to engage in **SELFCARE** activities:

Never	Rarely	Sometimes	Often	Always
☐	☐	☐	☐	☐

DRESSING

Does the young person show any of these behaviours related to DRESSING activities? *(please tick)*

☐ Refuses to wear clothing if they smell different to normal (change in washing powder, new from the shop)	☐ Doesn't notice dirty/wet clothes, or when they are rucked up
☐ Is irritated by clothing textures (labels, seams)	☐ Struggle to link zips/push through buttons
☐ Strips off clothing/shoes	☐ Doesn't adjust clothing to appropriate temperatures

Please describe any other strengths or difficulties the young person has with **DRESSING** activities:

Please tick how often the above behaviours impact the young person's ability to engage in **DRESSING** activities:

Never	Rarely	Sometimes	Often	Always
☐	☐	☐	☐	☐

TOILETING	
Does the young person show any of these behaviours during TOILETING? *(please tick)*	
☐ Holds nose/gags during toileting	☐ Smears faeces
☐ Seems fearful of sitting unsupported on toilet	☐ Unable to co-ordinate movement to wipe self
☐ Distress if contact with wee or poo when wiping	☐ Unaware/late recognition of need for going to the toilet
Please describe any other strengths or difficulties the young person has with **TOILETING**:	
Please tick how often the above behaviours impact the young person's during **TOILETING** tasks: **Never** ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always** ☐	

MEALTIMES	
Does the young person show any of these behaviours during MEALTIMES? *(please tick)*	
☐ Distressed by sound of others chewing	☐ Fatigues quickly during meals
☐ Has limited diet due to avoidance of textures/tastes of foods	☐ Does not notice food on face
☐ Gags at smells of foods	☐ Difficulties sitting still throughout meal
Please describe any other strengths or difficulties the young person has with **MEALTIMES**:	
Please tick how often the above behaviours impact the young person's ability to engage **MEALTIMES**: **Never** ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always** ☐	

PLAY	
Does the young person show any of these behaviours during PLAY activities? *(please tick)*	
☐ Startles with a loud noise	☐ Has difficulties judging force/pressure
☐ Dislikes getting messy	☐ Enjoys bumping, falling or crashing into objects or people
☐ Avoids movement games	☐ Moves/positions body awkwardly in relation to toy or play
☐ Reacts strongly to touch from others	☐ Has a weak grasp
Please describe any other strengths or difficulties the young person has with **PLAY**:	

Please tick how often the above behaviours impact the young person's ability to engage in **PLAY**:

Never	Rarely	Sometimes	Often	Always
☐	☐	☐	☐	☐

TABLE TOP TASKS			
Does the young person show any of these behaviours during TABLE TOP activities? *(please tick)*			
☐	Distracted/avoidant by others sitting in close proximity	☐	Encroaches into other people's personal space
☐	Dislikes unpredictable textures: paints, glues, tape	☐	Shifts and moves in chair
☐	Closes blinds / dims lights	☐	Leans and stabilises self on furniture
☐	Distracted by noise (from other rooms/corridors)	☐	May mouth/eat small objects (chalk, pencils, counters)

Please describe any other strengths or difficulties the young person has with **TABLETOP TASKS**:

Please tick how often the above behaviours impact the young person's ability to engage **TABLETOP TASKS**:

Never	Rarely	Sometimes	Often	Always
☐	☐	☐	☐	☐

P.E.			
Does the young person show any of these behaviours during P.E. activities? *(please tick)*			
☐	Avoids running and jumping activities	☐	Strong reliance on vision to sustain balance
☐	Dislikes physical support	☐	Difficulties planning how to catch/kick an approaching ball
☐	Distressed by noise of others/activities	☐	Difficulties judging force needed for activities
☐	Distracted by movement of others	☐	Difficulties copying a new movement or activity

Please describe any other strengths or difficulties the young person has with **P.E**:

Please tick how often the above behaviours impact the young person's ability to engage in **P.E**: **Never** ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always** ☐

Priorities (to be completed by school and home together)
Which 2 areas of your child's skills would you like to prioritise for support from the School Age Sensory Occupational Therapy Team?
Examples: Sensory regulation awareness/strategies, specific dressing skills (manage buttons/zips, putting on socks), specific personal care skills (tolerate hair brushing, teeth cleaning, tolerating clothing), specific motor skill (catching, throwing, climbing, managing stairs), sitting still for longer periods.

	Priority	**Current skills level**
Example	*Sitting still at a table for a meal*	*Able to sit still for a 2-minute adult led activity before leaving seat*
1		
2		

Strategies Trialled:
Please list what resources and strategies have been trialled with your child.
(N.B. It is recommended a young person will have a completed sensory passport and evidence of strategies trialled and/or self-led e-learnings completed by supporting adults prior to seeking further support)

My child has a sensory passport? Yes ☐ No ☐ If Yes, please attach copy
List strategies trialled from the online resource pack that have helped:
List any strategies trialled from the online resource pack which were less helpful:

Have key staff completed the self-led Introduction to Sensory Processing, Modulation and Sensory Strategies for use in Schools? Yes ☐ No ☐
Have parents completed the self-led Sensory Workshop for Parents and Carers? Yes ☐ No ☐

The Occupational Therapy team will review your questionnaire and contact you with further details. Please return your form to:		
Digital Forms:	**Posted Forms:**	
sensoryot@wsh.nhs.uk	Paediatric Occupational Therapy Service Bury Child Development Centre Hospital Road BURY ST EDMUNDS IP33 3ND Tel: 01284 775017 **(Bury St Edmunds Area)**	Paediatric Occupational Therapy Service St Helen's House 571 Foxhall Road IPSWICH IP3 8LX Tel: 01473 321230 **(Ipswich Area)**