**Children’s Therapy Service  
Autistic Spectrum Disorder and Sensory Occupational Therapy**

**We can only process your referral to the service once we have received the below form. If you have any difficulties in completing this form, please speak to the Children’s Therapy Department.**

Your Child’s name: Your Child’s Date of Birth:  
Your name: Your relationship with your child:  
Best contact phone number:   
Date:

**Please first complete the attached sensory questionnaire, then score the categories below.**

1. **How well do you feel you understand your child’s sensory needs on a scale of 0 to 10?**

*0 = I do not understand my child’s sensory needs at all.*

*10 = I thoroughly understand my child’s sensory needs.*   
  
0 1 2 3 4 5 6 7 8 9 10

1. **How well do you know how to manage your child’s sensory needs on a scale of 0 to 10?**

*0 = I do not know how to manage my child’s sensory needs at all.*

*10 = I thoroughly know how to manage my child’s sensory needs and have a range of sensory strategies used regularly.*  
0 1 2 3 4 5 6 7 8 9 10

1. **How much does your child’s sensory needs interfere with family/home life and your child’s life on the measure below?**

*0 = no impact  
10 = very severe impact (e.g. unable to complete any daily activities).*

Impact on family life:   
0 1 2 3 4 5 6 7 8 9 10

Impact on your child’s life:   
0 1 2 3 4 5 6 7 8 9 10