

CHILDREN'S SERVICES REFERRAL FORM

Date of Referral

Referrer

SERVICE YOU WISH TO REFER TO (Please see attached sheet for addresses of local services)

Primary Care Services

Children with non-complex needs should be referred to Primary Care. Copies of referral forms will be forwarded to all selected disciplines.

Dietetics ☐ Physiotherapy ☐ Speech & Language Therapy ☐

Occupational Therapy ☐ Social Work ☐ Psychology ☐

Community Medicine Service ☐ Nursing ☐

Other ☐ (specify) _____

Children's Disability Services

Children with complex needs should be referred to Children's Disability Services

A child has complex needs if he or she has a range of significant difficulties that require the services and support of a disability team.

Children's Disability Network Team ☐

CHILD'S PERSONAL DETAILS

Surname

First name

Gender

Date of Birth

Child's Age Years

Months

Address

Eircode

Parent/Guardian 1 Name

Parent/Guardian 2 Name

Relationship to child

Relationship to child

Telephone

Mobile

Email

Telephone

Mobile

Email

Address (If different from the child's)

Address (If different from the child's)

Country of Birth

First Language

Other languages spoken at home

Interpreter required

YES ☐ NO ☐

Number of siblings, their ages and details of any services they are attending

REASONS FOR REFERRAL

What are the main concerns and priorities for the child and their family?

1.

2.

3.

GENERAL PRACTITIONER DETAILS

GP Name/Practice	GP Telephone	Email
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GP Address

OTHER COMMUNITY HEALTHCARE SERVICES List all other services currently involved or waitlisted

Children's Disability Network Team <input type="checkbox"/>	Primary Care: Speech and language therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Psychology <input type="checkbox"/> Other (please give details) <input type="checkbox"/>
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Child & Adolescent Mental Health Service <input type="checkbox"/>	Tusla <input type="checkbox"/>
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Other (Please give details) ☐**CRECHE, PRE-SCHOOL OR SCHOOL DETAILS (Attach any Preschool or School Reports)**

Creche	Preschool	School	Child's Class
Address		Address	
Manager/Contact Person		Principal's Name	
Telephone		Telephone	
Email		Email	

MEDICAL HISTORY (Attach any relevant Medical Reports)

Relevant Medical History & Birth History:

Any diagnosis e.g. medical condition, learning disability, developmental disorder, hearing impairment. There may be more than one. Who made the diagnosis and date?

If the child is currently in hospital what date is he/she expected to be discharged?

Current medications

Allergies/Adverse medication events

Current investigations e.g. blood tests, scans, hearing tests

SOCIAL CIRCUMSTANCES**Relevant family and social history**

For example, family health or housing difficulties, financial or employment problems, bereavement or other stresses.

ANY OTHER RELEVANT INFORMATION

Please indicate whether referrer should be contacted prior to the initial appointment YES ☐ NO ☐

Are there any relevant risk factors in relation to this referral?

CONSENT: Referrals without signed consent of parent(s) / guardian(s) will not be accepted.

It is required by law that at least one of the child's legal guardians consents to the referral and signs this form. It is advisable that both parents/legal guardians are aware of this referral.

Definition of a Legal Guardian

All mothers, whether they are married or unmarried, have automatic guardianship status in relation to their children, unless they give the child up for adoption. A father who is married to the mother of his child also has automatic guardianship rights in relation to that child. This applies even if the couple married after the birth of the child.

A father who is not married to the mother of his child does not have automatic guardianship rights in relation to that child. If the mother agrees for him to be legally appointed guardian, they must sign a joint statutory declaration. However an unmarried father is automatically a guardian if he has lived with the child's mother for 12 consecutive months after 18/1/2016, including at least 3 months with the mother and child following the child's birth.

Children in Care

For children in voluntary care or on an interim order, the parents must sign the consent. For children on a care order the consent is signed by a Tusla Child and Family Agency social worker.

Child's Name**Date of Birth**

- **I give permission for my child to be referred to Primary Care Services /Children's Disability Services.**
YES ☐ NO ☐
- **I give permission for information about my child to be held by Primary Care Services/Children's Disability Services in accordance with obligations under the Data Protection Acts 1988, 2003 and 2018**
YES ☐ NO ☐
- **I give permission that in the event that this referral is not appropriate it may be shared with other relevant services to facilitate an onward referral. I will be contacted in advance of this information being forwarded on to another service.**
YES ☐ NO ☐
- **I give permission to Primary Care Services/ Children's Disability Services to contact and obtain relevant information in order to understand and address my child's needs from the professionals and services listed below, such as a hospital consultant, psychologist, speech & language therapist, teacher etc. Only those listed below will be contacted.**
YES ☐ NO ☐

Name (if available)	Service	Contact Details

Name of Parent 1/Guardian**Signature****Date:****Name of Parent 2/Guardian****Signature****Date****REFERRERS DETAILS**

Name:
Role (Parent/ Legal guardian, professional):

Date:**Address:****Telephone:****Mobile:****Email:****Signature:**