



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

ADDITIONAL INFORMATION FORM TO ACCOMPANY CHILDREN'S SERVICES REFERRAL FORM

Child aged from 12 months to 2 years 11 months

Date of Referral

Referrer

**In order to help services appropriately accept and prioritize referrals, this form should be completed by the parents or in consultation with them, and sent with the Children's Services Referral Form.
Please also attach any health or other reports you have on your child**

Surname

First Name

Date of Birth

Parents' names and contact details

BIRTH HISTORY (Please attach any relevant reports)

Length of Pregnancy (Weeks/days)

Place of Birth

Birth Weight

Was your child admitted to the neonatal unit? Yes No

Has your child ever been in hospital since they were born? Yes No
If Yes, for what reason?

Please give details of any medications, hospital and nursing needs, breathing and feeding supports

YOUR CHILD'S DEVELOPMENT Please note some questions may not be relevant for your child

1. Movement and Gross Motor Skills

Has your child achieved the following?

Rolling from back to tummy Yes At what age _____ Not yet

Sitting Yes At what age _____ Not yet

Crawling Yes At what age _____ Not yet

Walking independently Yes At what age _____ Not yet

Running Yes At what age _____ Not yet

If your child is walking do they tend to walk on tiptoes? Yes No

Is your child clumsier than other children their age? Yes No

Describe any concerns you have about your child's movement and gross motor skills:

2. Fine Motor Skills and Hand Movement

Which of the following can your child do?

Pick up small objects such as raisins Yes Not yet

Play with construction games e.g. building blocks or Duplo Yes Not yet

Use a pencil or crayon to scribble or draw Yes Not yet

Describe any concerns you have about your child's ability to use their hands

3. Communication, Speech and Language

Please explain how your child lets you know they want something? (e.g. crying, pulling, pointing, sounds, gestures, uses signs, uses pictures, words, sentences or a combination of these?)

Has your child achieved the following?

Babbling (e.g. gaga bada) Yes At what age _____ Not yet Skill achieved but since lost

Gestures such as wave "bye bye" and point? Yes At what age _____ Not yet Skill achieved but since lost

First word such as 'cat' 'more'? Yes At what age _____ Not yet Skill achieved but since lost

Putting two words together? Yes At what age _____ Not yet Skill achieved but since lost

How many words can your child put together now in a sentence?

Give an example of the kind of things your child says now:

Does your child have difficulty understanding what you say? Yes No

Please give details of any concerns you have about your child's speech, language, communication and voice:

4. Social Interaction, Relationships, Play and Leisure

When playing does your child allow you or other adults to join in? Always Sometimes Never

When playing does your child allow other children to join in? Always Sometimes Never

Describe how your child plays with others:

Describe what toys your child plays with and how they play with them:

What activities does your child like to do?

Does your child engage in pretend play and make believe games? Yes No

Is there anything you would like us to know about your child's play, friendships and activities?

5. Daily Living Skills**5A Food and Drink**

Do you have any concerns about your child's weight or growth? Yes No
If Yes, give details

Do you have any concerns about your child's nutrition or the range of foods they eat? Yes No
If Yes, give details

Describe your child's usual food, drinks and mealtime routine?

Can your child use a spoon to feed him or herself? Yes Not yet
Can your child drink from a beaker with a spout or a cup by themselves? Yes Not yet
Give details of any concerns about your child's ability to feed themselves

Do you have any concerns about **how** your child is chewing, swallowing or drinking? Yes No
If Yes please describe

Are mealtimes stressful? Yes No
If Yes please describe

Is your child on specialised feeds, drinks or foods? Yes No
If Yes, give details

5B. Urinary and Bowel Habits

Please describe what stage your child has reached with toilet training

Are there any issues around toileting? Yes No
If Yes, describe

5C. Sleep and Rest

Do you have concerns about your child's sleeping routine? Yes No
If Yes, describe:

Do you have any concerns about your child's level of energy? Yes No
If Yes, describe

6. Behaviour and Emotions

Have you any concerns about your child's emotional wellbeing and behaviour? At home Out and about
Describe any concerns

Do the following statements describe your child? (Please tick the appropriate boxes)

Frequent prolonged tantrums <input type="checkbox"/>	Aggressive <input type="checkbox"/>	Irritable <input type="checkbox"/>	Excessive Crying <input type="checkbox"/>	Clingy <input type="checkbox"/>
Upset for seemingly minor things <input type="checkbox"/>	Withdrawn or too quiet <input type="checkbox"/>	Doesn't like change <input type="checkbox"/>	Frustrated <input type="checkbox"/>	Worries a lot <input type="checkbox"/>

If Yes to any of the above, how often does this occur? Daily Weekly Monthly Less often
What impact does this have on your child and on your family and what helps to prevent problems?

7. Learning

Do you have any concerns about your child's ability to learn new skills? Yes No
If Yes, describe

Has anyone else expressed any concern about your child's ability to learn, such as the creche, a family member?
Yes No
If Yes, give details of the concern and who expressed it

8. Vision and Hearing

Does your child have vision problems which cannot be corrected with glasses? Yes No
If Yes, give details

Does your child attend a specialist service for their vision or for their hearing? Yes No
If Yes, give details

9. Sensory Processing

If you have concerns about your child's sensitivity to any of the following, either avoiding them or seeking them out, please tick:

Noise Touch Textures (such as fabrics) Movements Smells Food Lights

If you have ticked any of the above, please give details and describe how this impacts on everyday life

10. Is there anything else you would like to tell us about your child?

Tell us what your child enjoys and is good at as well as the things they find difficult:

What is your main concern and priority for your child?

Safety and Risk

Are there any issues which are a significant risk to the health and wellbeing of your child or others, such as physical injury to self or others, refusal to eat?

Please give details of who completed this form

Form completed by:

Relationship to child:

Contact details:

Date:

N.B. Please attach copies of any health or pre-school reports that you have.