CHILDREN'S SERVICES REFERRAL FORM

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.

Date of Referral	**Referrer**

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

GP Address

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

Children's Disability Network Team ☐	**Primary Care:** Speech and language therapy ☐ Occupational therapy ☐ Physiotherapy ☐ Psychology ☐ Other (please give details) ☐
Child & Adolescent Mental Health Service ☐	**Tusla** ☐
Other (Please give details) ☐	

CRECHE, PRE-SCHOOL OR SCHOOL DETAILS (Attach any Preschool or School Reports)

Creche **Preschool** **Address**	**School** Child's Class **Address**
Manager/Contact Person	**Principal's Name**
Telephone **Email**	**Telephone** **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 Children's Disability Services.** YES ☐ NO ☐
- **I give permission for information about my child to be held by 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 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:		