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|  | Dublin North City PCT REFERRAL FORM**Name of Referrer:****Referrer Contact No:****Date of Referral:**   | **Please return to:****Central Referrals Office** **Nexus Building, Units 4 & 5****Ground Floor, Block 6A****Blanchardstown Corporate Park 1, Dublin 15****Tel: 01 8975153****Email: referrals.dnc@hse.ie** |
| **Tick box for PCT/HSCN Service(s) you are referring to:***(Copies of this referral form will be forwarded to all selected disciplines)* |
| PHN/CRGN/CRM [ ]  Physiotherapy [ ]  Occupational Therapy [ ]  Speech & Language Therapy [ ]  Psychology [ ]  Social Work [ ]  Dietetics [ ]   |

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| **CLIENT DETAILS – Mandatory section – must be fully completed where relevant** |
| **S**urn**ame:**  | **First Name** |  | **Known As:**  |
| **Gender:** Male [ ]  Female [ ]  |  **DOB** |   *(date/month/year)* |
| **Address:** | **Telephone:**  **Mobile:**  |
| **Consent to receive appointment reminder or contact: Text Message** YES [ ]  NO [ ]  |
| **Next of Kin** | **Relationship to client:** | **Contact Number:** |
| **Contact Person (Carer/Guardian *)*** | **Relationship to client:** | **Contact Number:** |
| **Scheme Card Type:** PCRS (GMS card) [ ]  DVC [ ]  LTI [ ]  HAA [ ]  None [ ]  Other [ ]  **(please state)** |
| **Card Number:**  | **Expiry Date**  | **Private Insurance** YES [ ]  NO [ ]  **Company**  |
| **Languages Spoken**  |  **Interpreter required** YES [ ]  NO [ ]   |
| **GP Name/Practice**  | **GP Contact Number** |
| **Hospital discharge date (if applicable)** | **Hospital:** | **Consultant:** |
| **List all other services/ agencies involved in clients care:**       |
| **Home Help** **[ ]  Family/Home Support** [ ]  **Homecare Package** [ ]  **Details:**        |

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| **Medical / Development History** |       |
| **Diagnosis**  |       |
| **Medications** |       |
| **Reason for Referral *(please be specific)***       |
| **Clinical Assessment Scores** |
| Water-low score  |       | Barthel score  |       | Elderly Mobility Scale |       | Berg Balance Score |        |
| FRAT score |       | MMSE score  |       | EPDS score  |       | MUST score |       |
| **Relevant Investigations/Results:**       **Please attach** |

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| **Living Arrangements**  |  Lives alone **[ ]** Lives with Spouse **[ ]** Lives with family **[ ]**   |
| **Home Environment**  | 2 Storey House **[ ]** Bungalow **[ ]** Flat / Appt **[ ]** Living downstairs**[ ]** Other        |
| **Environmental Adaptations**  |        |
| **Mobility (**Please specify) | Independent **[ ]** 1 Stick **[ ]** 2 Sticks **[ ]** Walker/ rollator **[ ]** Wheelchair User **[ ]**  Other        |
| **Existing Assistive Equipment**  |       |

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| **SECTION A: Referrals For Adults - COMPLETE FOR THE RELEVANT DISCIPLINE(S) YOU ARE REFERRING TO.** |
| **Client Name:**       | **DOB:**       |

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| **OCCUPATIONAL THERAPY *(Attach relevant reports, order forms, quotations and prescriptions)*** |
| Difficulties with activities of daily living – specify       |
| Pressure care and Seating  | High Risk / pressure sore [ ]  Low risk [ ]   |  Pressure Grade (1-4) [ ]   |
| Manual handling issues for Carer | Yes [ ]  No [ ]  Type of carer       | Cognitive Assessment [ ]   |
| New assistive equipment-specify            | Housing adaptations – specify            |
| Other- specify      |

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| **PHYSIOTHERAPY** *Attach copies of reports of X-rays, MRI, DEXA scans, etc if available* |
| How long has the client had complaint? | 1-2 Weeks  | [ ]   | 2-4 Weeks | [ ]  | 1-3 Months | [ ]   | 3-6 Months  | [ ]   | 6+ Months  | [ ]  |
| Is the client experiencing difficulty with | Transfers [ ]  | Walking [ ]  | Respiratory Difficulties [ ]  |
| History of falls last 12 months Yes [ ]  No[ ]  |  No’s of falls       | Severity of symptoms Mild [ ]  Moderate [ ]  Severe [ ]  |
| 0ther - specify      |

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| **PHN/CRM/CRGN** *Attach Any Relevant Reports/ Information/ prescriptions* |
| Nursing assessment [ ]  | Continence problem [ ] [ ] Chronic Illness Management [ ]  [ ]  | Chronic illness management [ ]   | Respite [ ]  |
| Existing pressure sore Yes [ ]  No [ ]   | If Yes What Stage?  **Stage** 1 [ ]  2 [ ]  3 [ ]  4 [ ]   |
| Leg ulcer/pressure care/wound care [ ] [ ] If Yes Include details      [ ]  [ ]       | If yes include details       |
| Health Education/Promotion [ ]  Specify      [ ] Specify       | Preventive/Anticipatory Care [ ]  Specify     [ ] Specify       |

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| **COMMUNITY DIETETICS** *Attach copies of relevant bloods results & medications prescribed. Growth Charts must be supplied for children*. |
| Weight       Height       Has there been unplanned weight loss in the last 3-6 months Yes[ ]  No[ ]  |
| Is the client on oral nutrition supplements? Yes [ ]  No[ ]  If “yes” please supply details.  |

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| **PSYCHOLOGY** *Attach copies of psychiatric reports if relevant, and tick below as appropriate providing brief details* |
| Anxiety [ ]  | Relationship Difficulties [ ]  | Stress and Trauma [ ]  | Depression [ ]  |
| Coping with injury/illness [ ]  | Life cycle development issues [ ]  | Adjustment Problems [ ]  | Bereavement [ ]  |
| What do you hope Psychology can do?       |

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| **SPEECH & LANGUAGE THERAPY** *Attach Any Relevant Reports/ Information* |
| Communication [ ]  | Swallow [ ]  **Urgent swallowing difficulties should be referred to GP / DDOC** |
| Current route of nutrition:       | Chest status:       |
| Current diet and fluids:       |
| Details of previous SLT involvement:       |

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| **SOCIAL WORK –** *Add additional reports* |
| Family / Community Support[ ]  | Adjustment to life issues [ ]   | Vulnerable Adults [ ]  |
| Group work [ ]  | Carers Support [ ]   | Domestic / community violence [ ]  |
| Other – Specify       |
| What do you hope Social Work can do?       |

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| **Any Other Relevant Information** |
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| **SECTION B: Referrals for Children Under 18 Years – COMPLETE FOR THE RELEVANT DISCIPLINE(S) ONLY.** |
| **Child’s Name:** | **DOB:** |

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| **Any Behavioural / Management concerns** |       |

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| **Services involved in Child’s Care** |  |
| **Pre- school / School / College:**       | **Class:**       |
| Early intervention service [ ]  |  6 – 18 yrs services [ ]  | ASD Service [ ]  | CAMH Service [ ]  | Child protection / Family support [ ]  |
| Specify Location:       | Paediatric Hospital:       | Other:       |

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| **OCCUPATIONAL THERAPY** *(Attach relevant reports, order forms, quotations and prescriptions)* |
| Difficulties with activities of daily living - specify       | Pressure care [ ]   | Seating/Positioning [ ]   |
| Difficulties with: Fine Motor [ ]  | Balance [ ]  | Gross Motor [ ]  | Co-ordination [ ]   | Cognition / Learning [ ]  |
|  Behaviour [ ]  | Play [ ]  | Sensory processing [ ]  | Attention / Concentration [ ]  |
| What do you hope OT can do?       |

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| **PHYSIOTHERAPY Attach Any Relevant Reports or Information** |
| How long has the client had complaint? | 1-2 Weeks | [ ]   | 2-4 Weeks | [ ]  | 1-3 Months | [ ]   | 3-6 Months  | [ ]   | 6+ Months  | [ ]  |
| Severity of symptoms Mild [ ]  Moderate [ ]  Severe [ ]  | Difficulties with: Balance [ ]  Co-ordination [ ]   |
| Difficulties with: Crawling [ ]  Walking / Running [ ]  Respiratory Difficulties [ ]  Functional Difficulty - specify       |
| Other - specify       |

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| **PHN/CRM/CRGN** *Attach Any Relevant Reports or Information* |
| Child Development Concern - Tick Box | Weight/Height | [ ]  | Nutrition | [ ]  | Vision [ ]  Hearing [ ]   |
| Nursing Assessment | [ ]  | Urinary/ Bowel Problem  | [ ]  | Wound care |  [ ]  | Health Education/Promotion [ ]  |
| Other - specify      Specify       |

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| **COMMUNITY DIETETICS** *Attach copies of relevant bloods results & medications prescribed.* |
| Growth Charts must be supplied for children: Please ensure referral details on Page 1 is completed fully |

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| **PSYCHOLOGY** *Tick as appropriate and provide brief details* |
| Anxiety  | [ ]  | Developmental Delay | [ ]  | Behavioural Difficulties  | [ ]  | General Emotional Difficulties |  [ ]  |
| Sleeping/ Feeding/Toileting | [ ]  | Adjustment | [ ]  | Stress / Trauma | [ ]  | Child in Care YES [ ]  NO[ ]  |
| What do you hope psychology can do?:       |

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| **SPEECH & LANGUAGE THERAPY** Tick as appropriate*Attach Any Relevant Reports or Information* |
| Any Previous SLT involvement? Yes [ ]  No [ ]  Please attach report  | Date/Type Hearing Test       | Stuttering [ ]  |
| Hearing Difficulties [ ]  | Understanding of Language [ ]  | Expressive Language [ ]  | Hoarseness/voice concerns [ ]  | Speech Sounds[ ]  |

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| **SOCIAL WORK**  - Add additional report |
| Family/Community Support | [ ]  | Adjustment to life issues | [ ]  | Other - Specify |

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| **Any Other Relevant Information - Note : Please attach available reports** |
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| **Client Name:**       | **DOB:**       |

**You must complete either Section A (Consent for Children) or Section B (Consent for Adults) along with Section C (Referrer Details) Note: Referrals will not be processed without completion of these Sections**

**Section A**

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| **CONSENT for CHILDREN :** Referrals without written consent of parent(s) / guardians for child & adolescent referrals will not be accepted**Please note:** Consent can be completed on the referral form provided or maybe completed on a separate written consent form and held on the client file. Where consent is signed on the separate form please forward a copy of the consent form to the central office for the specific discipline requiring this consent. |
| **Has parent(s)/Guardians consented in writing to this referral?**  YES [ ]  NO [ ]   |
| **Has parent (s)/Guardians consented in writing to sharing of information?** YES [ ]  NO [ ]  |

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| **I/we consent to the referral of (Insert name of child)** |

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| **Name of Mother/Guardian:** | **Contact No:** |
| **Address:** |
| **Signature:** | **Date:** |

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| **Name of Father/Guardian:** | **Contact No.** |
| **Address:** |
| **Signature:** | **Date:** |

**Section B**

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| **CONSENT for Adults:** Referrals must have consent from the individual being referred. **Please tick the relevant boxes showing consent for referral and for information sharing has been given.** Referrals will not be processed without completion of these boxes. **Please note:** Consent can be completed on the referral form provided or maybe completed on a separate written/verbal consent form and held on the client file |
| **Has client consented to this referral?**  YES [ ]  NO [ ]  **Verbal**  [ ]  **Written** [ ]   |
| **Has client consented to sharing of information?** YES [ ]  NO [ ]  **Verbal**  [ ]  **Written** [ ]   |

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| **Name of Client:** | **Contact No:** |
| **Address:** |
| **Signature:** | **Date:** |

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| Where a client cannot give consent, please provide details of the individual/family member who has been informed of the referrall |
| **Name of Family Member/ Carer:** | **Contact No:** |
| **Address:** | **Date:** |

**Section C**

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| **Referrer details:** | **Name of referrer:** | **Title:**  |
| **Address:**  | **Date:** |
| **Telephone:** | **Fax:**  | **Email:** |
| **Signature:**  | **Preferred Contact Method:** Post[ ]  Telephone [ ]  Fax [ ]  Email [ ]  |
| **Staff Precautions / Risk: Should the Referrer be contacted prior to contacting the family** YES [ ]  NO [ ]   |

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| **Additional Contact Details**  |
| **Name:** | **Title:** | **Telephone:       Fax:       Email:** |
| **Name:** | **Title:** | **Telephone:       Fax:       Email:** |

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| **Office Use - only** |
| **PCT Name:** | **DED Name:** | **Date Received:** |
| **Client No:** | **Priority:** | **New / Re Ref:** | **Processed by:** |
| **Reason:** | **Source:** | **Diagnosis:** |  |