Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

PRIMARY CARE TEAM
REFERRAL FORM

Please ensure all sections are completed & consent received from Client or Parent / Guardian

Cavan Monaghan Primary & Community Care

PCT Name: _____

Tick box for discipline(s) you are referring to: ☐ Occupational Therapy ☐ PHN / CRGN ☐ Physiotherapy

☐ Clinical Psychology ☐ Social Work ☐ Speech and Language Therapy ☐ Dietician

Client Forename		Client Surname	

Gender ☐ Male ☐ Female

Patient card type: None ☐ GMS ☐ DVC ☐ LTI ☐

Address _____

Card Number: _____

DOB _____ *Day* _____ *Month* _____ *Year*

Tel/Mobile No. _____

GP Name (or stamp) _____

Contact Person _____ Address _____

Relationship to client _____

Tel / Mobile No. _____ Tel No _____ Fax No. _____

Medical Diagnosis

Reason for Referral

Please also fill in the relevant section on page 2.

Relevant History/ Issues of Concern

Medications

Social Circumstances Lives alone? ☐ Yes ☐ No With whom? _____

Language Used _____ Is Assistance required with Language ☐ Yes ☐ No

If facilitating hospital discharge, date of discharge: _____ Hospital: _____

Mobility ☐ Independent ☐ With Aid ☐ Wheelchair ☐ Immobile

Has the client fallen in the past 3 months: ☐ Yes ☐ No

Other professionals currently involved in client's care? ☐Yes ☐ No ☐ Don't know

If "yes" provide name & contact details:

Are there any potential risks to staff visiting this client ☐ Yes ☐ No If yes, specify _____

CONSENT: This referral must have the written consent of the client (or that of a parent/guardian in the case of a child) before it will be accepted by the Primary Care Team

The reasons why I am being referred to the Primary Care Team have been explained to me. I understand that my circumstances may be discussed by members of the team and possibly other Health Professionals. I understand that all staff involved will ensure that my personal information will be managed respectfully and in the strictest confidence. I consent to this referral.

Adult:	**Name:**	**Signature:**	**Date:**

Child:	**Name:**		
I consent to the above referral	**Mother/Guardian Signature:**		
I consent to the above referral	**Father/Guardian Signature:**		

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Cavan Monaghan PCS

OFFICE use only: Date Referral Received: _____
Priority Rating: _____
Date of first Appointment _____

Essential Information for Discipline Referrals

*This is **not** an assessment form; it is for the purpose of Referral ONLY*

FOR ALL REFERRALS – complete relevant Sections only

PHN / CRGN

☐ Continence problem
☐ Chronic Illness Management
☐ Health Education / Promotion
☐ Day Care
☐ Home Supports
☐ Leg ulcer / pressure care / wound care
☐ Nursing assessment
☐ Respite
☐ Preventive / Anticipatory Care
☐ Post Natal Support
☐ Other:
(specify) _____

Existing Pressure Sore ☐ Yes ☐ No Stage ☐ 1 ☐ 2 ☐ 3 ☐ 4 Waterlow Score _____

Has the client had a recent fall or at risk of falls? ☐ Yes ☐ No

Assessments: Barthel Score /20 MMSE Score /30 EPDS Score /30 Other:

OCCUPATIONAL THERAPY :

☐ Assessment: ☐Physical ☐Psychological ☐Social
☐ Assessment in activities of daily living: ☐Toileting ☐Bathing ☐Dressing ☐Feeding
☐ Advice on Special Housing adaptations for disabled persons
☐ Seating/Wheelchair assessment and training
☐ Hoist assessment and training
☐ Assessment and instruction in the use and care of splinting

PHYSIOTHERAPY *Attach copies 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 problem getting ☐ Better ☐ Worse ☐ Unchanged

Night pain: ☐ Yes ☐ No	Referred Pain: ☐ Yes ☐ No	Off Work due to condition ☐ Yes ☐ No

CLINICAL PSYCHOLOGY *Attach copies of all assessments & reports available e.g. SLT, Social Work, School etc.*

☐ Assessment ☐ Therapeutic Intervention ☐ Professional Consultation

Main presenting problem:
☐ Emotional problems *e.g. anxiety, low mood, poor social skills etc.*
☐ Behavioural problems *e.g. anger, conduct problems etc.*
☐ Adjustment difficulties *parental separation, trauma etc.*
☐ Parenting support
☐ Other *please be specific* _____

Please note: Therapeutic Intervention will include group, family and individual, where appropriate. Willingness to participate is assumed on provision of written consent.

COMMUNITY NUTRITION AND DIETETICS (*attach biochemistry and feeding regimes as indicated*) Reason For Referral:-

☐ Obesity BMI > 30 - Obesity BMI > 25 + 1 risk factor e.g. hypertension
☐ Cardiovascular Disease- with BMI > 25kg/m2 + 3 risk factors e.g. hyperlipidaemia
☐ Malnutrition - with MUST score > 2 (using MUST screening tool)
☐ Type 2 DM - not seen by Dietitian/attended XPERT in last 12 mths & HbA1c >53mmols/l
☐ Dysphagia - Has the client been seen by SLT? Yes ☐ No ☐ ***or*** Has the client been referred to SLT? Yes ☐ No ☐
☐ Enteral Feeding - ☐ IGT ☐ Coeliac Disease ☐ Inflammatory Bowel Disease

Weight_____(kg) **Height_____(m)** **BMI_____(kg/m^2)**

SOCIAL WORK

☐ Psychosocial Assessment of need ☐ Adjustment to life issues ☐ Vulnerable older person
☐ Carer Support ☐ Advocacy ☐ Family Conflict resolution

☐ Other (Please Specify):

SPEECH & LANGUAGE THERAPY

☐ **Feeding, Eating, Drinking or Swallowing (FEDS) issue:** ☐ Recent ☐ Reoccurrence ☐ Developmental

☐ **Communication issue:** ☐ Recent ☐ Reoccurrence ☐ Developmental

Involves: ☐ Understanding language ☐ Expressive language ☐ Speech sounds
☐ Stammer ☐ Voice ☐ Other (specify):

If aged 0-18 years please complete:
School/Preschool: ☐ Hearing Difficulty ☐ Behaviour Difficulty ☐ Developmental Delay
Comments:

Referrer Name _____ Title _____

Address _____ Date ____/____/____

Signature _____ Tel No. _____

Preferred method of contact: ☐ Telephone ☐ Fax ☐ Email