Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Community Paediatric
Physiotherapy
Block 34, St. Finbarr's Hospital
Douglas Rd, Cork
021 492 7850

COMMUNITY PAEDIATRIC PHYSIOTHERAPY REFERRAL FORM:

Childs Name: _____ **Date of Birth:** _____

Address: _____

Parent(s)/Guardian: _____ **Contact No:** _____

Does this patient have a valid GMS/LTI Card? Yes/No GMS Number:_____ **Exp.date** _____

Patients GP:_____ **Patients PHN**:_____

Reason for referral to PCT Paediatric Physiotherapy;

_____

_____

Other referrals made for this condition :OT SLT PSYCHOL CAMHS AMO Consultant_____

Investigations done or pending: _____

MedicalHistory:_____

_____

Has this child met developmental milestones as expected? Yes/No Note delays/concerns:

_____

What other services is this child accessing? Audiology Ophthalmology SLT OT Psychol CAMHS Dietician other _____

Permission given for referral; Yes/No **Permission given to contact other services** Yes/No

NB*: Referrals are prioritised by clinical need. Please ensure all information is filled on this form to avoid unnecessary delays in seeing your patient. Please attach all relevant reports.*

Children enrolled with another MDT child development service cannot simultaneously be referred to this NLSL PCC Paeds Physio services.
Please send completed referrals to Paeds Physio Block 34 St. Finbarr's Hospital, Douglas Rd. Cork.

Referrer name and service: _____ **PHN AMO OT SLT PSYCH GP Acute**

Referrer contact number and email: _____

Referrer Signature: _____ **Date:** _____

Physio/Office use only

Date Ref Received Office: _____ Date Databased: _____

Received Clinic: _____ Initial apt.: _____ Location: _____

Discharge Date: _____ D/C Report sent: _____

Onward Referral: _____

Physiotherapist Name: _ Signature: