Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Dublin North City
PCT REFERRAL FORM

Name of PCT:
Date of Referral:

Please return to:
Primary Care Team Central Referrals Office,
Dublin North City Health Services Area
Ballymun Healthcare Facility,
Ballymun, Dublin 9
Tel: 01-8467005
Fax: 01-8467505
e-mail: referrals.dnc@hse.ie

Tick box for PCT/HSCN Service(s) you are referring to: *(Please note copies of this referral form will be forwarded to all selected disciplines)*

GP /Practice Nurse ☐	PHN/CRGN/CRM ☐	Physiotherapy ☐	Occupational Therapy ☐
Speech & Language Therapy ☐	Psychology ☐	Social Work ☐	Dietetics ☐

CLIENT DETAILS – Mandatory section – must be fully completed where relevant

Surname:	**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**	
GP Address			
Hospital discharge date (if applicable)	**Hospital:**	**Consultant:**	
List all other services/ agencies involved in clients care:			
Home Help ☐ **Family/Home Support** ☐ **Homecare Package** ☐ **Details:**			

REFERRAL DETAILS - Mandatory section – must be fully completed where relevant

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**

SOCIAL CIRCUMSTANCES (Complete where appropriate)

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	

SECTION B: Referrals for Children Under 18 Years – COMPLETE FOR THE RELEVANT DISCIPLINE(S) ONLY.	
Child's Name:	DOB:

Any Behavioural / Management concerns	

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:	

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?				

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					

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 ☐	Specify		
Other			

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

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?:			

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 ☐

SOCIAL WORK - Add additional report

Family/Community Support ☐	Adjustment to life issues ☐	Other - Specify

Any Other Relevant Information - Note : Please attach available reports

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

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 ☐

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

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

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

Section B

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 ☐

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

Where a client cannot give consent, please provide details of the individual/family member who has been informed of the referral

Name of Family Member/ Carer:	Contact No:
Address:	Date:

Section C

Referrer details				
Name:	Title:			Date:
Address:	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 ☐				

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

Office Use - only			
PCT Name:	DED Name:		Date Received:
Client No:	Priority:	New / Re Ref:	Processed by: