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|  | Dublin North CityPCT 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 downstairsOther |
| **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:** | |  |