|  |  |  |
| --- | --- | --- |
| **E:\:HSE Logo.jpg** | MEATH PRIMARY CARE TEAMSREFERRAL FORM**Please ensure ALL relevant sections are complete & consent received from Client, Parent/Guardian** **(Reviewed September 2018)** | **Please return to:**HSE, Dublin NE, Laytown Health Centre,Laytown, Co Meath. A92 VA03Tel: 041 9827012 Fax: 041 9820180e-mail: **eastmeath.referrals@hse.ie** |
| **Tick box for Service(s) you are referring to:***(Please note copies of this referral form will be forwarded to all selected disciplines)* |
| Nutrition & Dietetics [ ]  Occupational Therapy [ ]  PHN/CRGN [ ]  Physiotherapy [ ]  Psychology [ ]  Primary Care Social Work [ ]  Speech and Language Therapy [ ]   |
| **S**urn**ame:**  |
| **First name:**  | **Card Type** GMS [ ]  DVC [ ]  LTI [ ]  Other [ ]  |
| **Known As:**  | **Card Number:**  |  |
| **Gender:** Male [ ]  Female [ ]  |  **DOB** |  *(date/month/year)* |
| **Address:****Post Code:** | **Email address** *(optional)*  |
| **Consent to receive:****Emails** YES [ ]  NO [ ]  **Text Messages** YES [ ]  NO [ ]  |
| **Telephone:**  **Mobile:**  |
| **Contact Person** *(if required)*  | **Relationship to client:**  | **Contact Number:** |
| **Interpretive services required** YES [ ]  NO [ ]  | **Which language?**  |
| **Pre-school/School**  | **Class**  |
| **GP Name/Practice**  | **Contact Number for GP**   |
| **Hospital discharge date (if applicable)** | **Hospital** |
| **Diagnosis / Medical History** |
| **Reason for Referral *(please be specific)***       |
| **CONSENT:** Some child & adolescent referrals require the signed consent of **BOTH** parents/guardians. In this instance the form may be returned to you for a second signature |
| **Has the client/parent consented to this referral? Yes** [ ]   **No** [ ]  (must be completed for Adults & Children) |
| **Has the client/parent consented to sharing of information? Yes** [ ]   **No** [ ]  (must be completed for Adults & Children) |
| **I/We consent to the referral of (insert name of child):**      |
| **Name of Parent/Guardian:**       | **Contact No. & Address:**       |
| **Signature:**       | **Date:**       |
| **Name of Parent/Guardian:**       | **Contact No. & Address:**       |
| **Signature:**       | **Date:**       |
| **REFERRER** |
| **Name:**       | **Title:**       |
| **Address:**       | **Contact No.:**       | **Email:**       |
| **Signature:**       **Date:**       | **Preferred Method of Contact: Post** [ ]  **Telephone/Mobile** [ ]  **Email** [ ]   |
| **Clinical Assessment** |
| **Existing pressure sore**   | **Yes** [ ]   **No** [ ]   | **Stage** 1 [ ]  2 [ ]  3 [ ]  4 [ ]   | **Water-low score** [ ]  |
| **Assessments** | **Barthel score** [ ] /20 | **MMSE score** [ ] /30  |  **EPDS** score [ ] /30 |
| **Please note the service(s) involved in client's care** |
| Adult Intellectual Disability | [ ]  | Enable Ireland | [ ]  Elderly Day Centre/Hospital [ ]   |
| CAMHS  | [ ]  | Family Support  | [ ]  Physical & Sensory Disability [ ]  |
| Children’s Disability Service (6-18)  | [ ]  | Palliative Care | [ ]  Adult Mental Health Service [ ]  |
| **Social** *(Complete where appropriate)* |
| **Living Alone** YES [ ]  NO [ ]  Home Support YES [ ]  NO [ ]  |
| **Social Situation** |       **Mobility**       |
| **Other relevant information**       |
|  |
| **Client Name:**       | **DOB:**       |
| **PLEASE COMPLETE FOR THE RELEVANT DISCIPLINE** |
|  |
| **NUTRITION & DIETETICS** |
| Malnutrition (must score >2) [ ]  | Enteral Feeding [ ]  | Dysphagia – Has client been referred to SLT? [ ]  | Yes [ ]  No [ ]  |
| Coeliac Disease [ ]  | Irritable Bowel Syndrome [ ]  | Inflammatory Bowel Disease [ ]  |  |
| Pre-diabetes [ ]  | Obesity [ ]  | Type 2 Diabetes – referred to structured patient education? [ ]  | Yes [ ]  No [ ]  |
| Hyperlipidaemia [ ]  | Hypertension [ ]  | Other (please specify) [ ]  |  |
| **Paediatric Growth Charts & relevant bloods must be supplied** |
| Coeliac Disease [ ]  | Overweight (BMI > 91st Percentile) [ ]  | Iron Deficiency Anaemia [ ]  |
| Constipation [ ]  | Fussy eating for > 6 months (Group Session) [ ]  | Other (please specify) [ ]   |
| **OCCUPATIONAL THERAPY** |
| Difficulties with activities of daily living - please specify.       |
| Difficulties with transfers - please specify.       |
| Seating/Positioning [ ]  Pressure care [ ]  Wheelchair assessment: occasional user [ ]  full time user [ ]   |
| Other Relevant Information       |
| **PHN/CRGN** *Attach Any Other Relevant Reports or Information* |
| Continence problem  | [ ]  | Day Care | [ ]  | Nursing assessment | [ ]  | Psychological Support [ ]   |
| Chronic Illness Management | [ ]  | Home Supports  | [ ]  | Respite  | [ ]  | Other (specify)       |
| Health Education/Promotion | [ ]  | Leg ulcer/pressure care/wound care | [ ]  | Preventive/Anticipatory Care | [ ]  |  |
| **CHILD HEALTH**  |
| **Audiology - Date of Test**  | **Type of Hearing Test**  | **Outcome**  *(please attach report)* |
| Tick if you are concerned about any of the following:  |
| Vision | [ ]  | Weight  | [ ]  | Height  | [ ]  | Nutrition | [ ]  | Hearing | [ ]  |
|  |
| **PHYSIOTHERAPY** *Attach copies of reports of X-rays, MRI, DEXA scans, etc if available* |
| Relevant Investigations/Results:       |
| How long has the client had complaint? | 1-2 Weeks | [ ]   | 2-4 Weeks | [ ]  | 1-3 Months | [ ]   | 3-6 Months  | [ ]   | 6+ Months  | [ ]  |
| Is there a history of falls in the last six months | YES [ ]  NO [ ]  | Night pain: | YES [ ]  NO [ ]  |
| Is the client experiencing difficulty with | transferring | [ ]  | walking | [ ]  | Unable to work as a result of the condition  | [ ]  |
| **CHILD PSYCHOLOGY** *Tick as appropriate and provide brief details* |
| Anxiety  | [ ]  | Bed Wetting/Soiling  | [ ]  | Behavioural Difficulties  | [ ]  | General Emotional Difficulties | [ ]  |
| Query ADHD  | [ ]  | Sleeping Difficulties  | [ ]  | Suicidal Ideation  | [ ]  | Abuse (specify type) | [ ]  |
| Deliberate Self-harm  | [ ]  | Depression | [ ]  | Eating Difficulties  | [ ]  | Child in Care |  YES [ ]  NO [ ]  |
| Additional Comments:       |
| **SOCIAL WORK SERVICE** *Reason for Referral* |
|       |
|       |
|       |
|       |
| **SPEECH & LANGUAGE THERAPY** *Tick as appropriate* |
| **Children’s Services**  |
| Non-Talker  | [ ]  | Immature Pronunciation | [ ]  | Stammer/Fluency Problems | [ ]  | Hoarseness/voice concerns  | [ ]  |
| Delayed language  |  [ ]  | At what age did the child use first words?       | Use two-three words together?       |
| Feeding Difficulties  |  [ ]  Hearing Difficulties [ ]  |
| **Adult Services**  |  |
| Speech Assessment [ ]  Language Assessment [ ]   |
| Describe the client’s presentation:       |
| Swallow Assessment: [ ]  Please state current diet / route of nutrition       |  |
| **FAILURE TO COMPLETE THE SECTION FOR CONSENT WILL RESULT IN - THE FORM BEING RETURNED TO THE REFERRER** |