Paediatric Resource Clinic – Referral Form

(Version 1: 04/10/12.)

☐ East Limerick Team ☐ Blackberry Team ☐ West Limerick team ☐ St. Joseph's Foundation

☐ North Tipperary Team ☐ Treehouse Team ☐ Clare Team (Tick as appropriate)

(Section A)

Name:	**DOB:**	**Gender:**
Parent(s)/Guardian(s):		
Address:	Tel No: Mobile No:	
GP Name	Consultant Name	
Address	Address	
Tel. No.	Tel. No.	

Pre-School /School Name:	**Address**	**Pre-School or School (contact and Tel No.)**

Existing reports attached? ☐ **YES** ☐ **NO**

This section must be completed for referral to be processed.

Reason for Referral: (Section B)

Resource Clinic Discipline Requirements (please tick):

Primary Care Team Members ☐ **OT** ☐ **PT** ☐ **SLT** ☐ **SW** ☐ **PSYCH** (Please specify names and contact details below)

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_____

Child Development Team Members ☐ **OT** ☐ **PT** ☐ **SLT** ☐ **SW** ☐ **PSYCH**

Resource Clinic – Referral Form for: _____ DOB: _____

This section must be completed for referral to be processed.

Assessment/ Intervention that has occurred to date & Reasons for Referral: (Section C)

Occupational Therapy: Currently attending this discipline? ☐ YES ☐ NO	
Physiotherapy: Currently attending this discipline? ☐ YES ☐ NO	
Psychology: Currently attending this discipline? ☐ YES ☐ NO	
Social Work: Currently attending this discipline? ☐ YES ☐ NO	
Speech & Language Therapy: Currently attending this discipline? ☐ YES ☐ NO	

Other: (please Specify) Please use separate sheet to record other

CONSENT FOR REFERRAL HAS BEEN RECEIVED FROM PARENT(S)/GUARDIAN(S): Yes ☐ No ☐

Referrer:	**Address:**	**Tel No:**
Job Title:		**email:**
Signature:	**Referral Received by: _____**	
Date:	**Referral received on (date): _____**	

Additional Information