REFERRAL FORM

☐ Early Intervention Team

☐ School Age Team

Mid West Disability Services
Child Development Teams

For more information please visit Regional For more information please visit Regional Website www.mwcds.ie

(Section A)

Name:	**DOB:**	**Gender:**
Parent(s)/Guardian(s):		
Address:	Tel No: Mobile No:	
Medical/LTI Card No:	Health Centre:	
GP Name:	Consultant Name:	
Address:	Address:	
Tel. No.:	Tel. No.:	
Pre-School /School Name: / **Address:**	**Pre-School or School (contact and Tel No.):**	
Is child applying through Assessment of Need Process?	Yes No	

Please list the names and contact details of other services and/or Health Care Professionals previously and currently involved in the child's care (i.e. Paediatrician, PHN, Social Work, CAMHS, Community SLT, Community Psychology, Barnardos, Respite Services, Private Therapists):

Name:	Tel No:
Name:	Tel No:
Name:	Tel No:
Name:	Tel No:
Relevant reports attached?	Yes No

Diagnoses: **(Section B)**

This section must be completed for referral to be processed.

	Diagnosis if known:			**Diagnosis Queried:**
	Please state exact nature of diagnosis:	**Date diagnosis received:**	**Diagnostician:**	**Please indicate nature of query:**
Intellectual disability **i.e. mild/moderate/severe**				
Physical disability				
Sensory disability **(hearing or vision)**				
ASD / ASD Query ***□ Yes / □ No***	**Section D** must be completed if concerns are in relation to Autistic Spectrum Disorder			
Global Developmental Delay				
Other **i.e. (please specify)**				

Disciplines Required & Reasons for Referral: (please tick as appropriate) **(Section C)**

This section must be completed for referral to be processed.

Occupational Therapy:

Self care		Fine motor skills		Accessing environment		Equipment		Sensory issues	

Physiotherapy:

Abnormal muscle tone		24hr postural management		Equipment		Gross Motor skills		Balance		Surgery	

Psychology:

Behaviour		Emotional needs		Social (inc family issues)		Query around diagnosis/Level of Functioning		Adaptive functioning	

Speech & Language Therapy:

Expressive language		Receptive language		Articulation / Phonology		AAC user (Communication Aid)		Eating, drinking, swallowing difficulties		Social skills/ pragmatics	

Other:

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

Referrer:	**Address:**	**Tel No:**
Job Title:		**email:**
Signature:	***Please consult the referral pack regarding which team is appropriate for this child.***	
Date:	**(i.e. details of catchment areas for Early Intervention Teams or lists of schools served by School Age Teams.)**	

(Section D)

The following information must be completed where there is a query in relation to the possible presence of Autistic Spectrum Disorder.

As you will be aware an ASD assessment is a detailed and lengthy process and we need to ensure that we have enough information to warrant placing a child on a long waiting list. In order for assessment to proceed we require information on the child's needs in the areas of social interaction and communication and details of any restricted, repetitive and stereotypical behaviours and interests.

* *Significant* means these problems occur frequently, in a variety of settings, and have a negative impact on the child's life.

Does this child have significant* difficulties in several of these areas of development: social communication, mixing with other children, imaginative play, unusual routines or rituals, and unusually narrow or odd patterns of behavior and interests? Yes ○ No ○

Please describe:

Does this child also display a broad range of other, equally prominent difficulties, such as impulsivity, school problems, hyperactivity, aggression, conduct problems, sadness, or worry? **

Yes ○ No ○

Please describe:

Has this child's parent(s) / Guardian(s) been informed of and consented to this referral for an ASD Screening and/or Diagnostic Assessment? Yes ○ No ○

Please provide any additional information that you feel may be of use to the team when undertaking this assessment. E.g., Speech and Language Therapy reports and Cognitive Assessment Reports.

Additional Report Provided: Yes ○ No ○

Have any other conditions been considered and ruled out? Yes ○ No ○

Has the child received any therapeutic intervention to date? Yes ○ No ○

Any other comments that may be useful with respect to the child/young person's referral

Referrer Name:	Signature:	Date: