

CHILDREN'S DISABILITY RESPITE REFERRAL FORM

Child Details			
Child's Name:			
Address:	Eircode:		
Date of Birth:		Gender:	
Nationality:		Religion:	
First Language:		PPS Number:	
Are there any Child Protection concerns with this child and family?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>		
Parents/Legal Guardians			
Name:			Name:
Relationship:			Relationship:
Legal Guardian: Yes <input type="checkbox"/> No <input type="checkbox"/>			Legal Guardian: Yes <input type="checkbox"/> No <input type="checkbox"/>
Address:			Address:
As Above: <input type="checkbox"/> Eircode: <input type="checkbox"/>			As Above: <input type="checkbox"/> Eircode: <input type="checkbox"/>
Home Phone No:			Home Phone No:
Mobile:			Mobile:
Email:			Email:
Referrer Details			
Name of Referrer:			
Relationship to Child:			
Address:		Eircode:	
Telephone Number:			
Email/Other:			
Referrer's Signature:		Date:	

Parent/Guardian Consent

Parent/Guardian permission is required to make a referral to LauraLynn Children's Disability Respite:

By signing below, you consent to the following:

- That health related information regarding the child being referred, may be shared with, and given to LauraLynn Children's Disability respite service.
- That LauraLynn may seek additional health related information and reports regarding the child being referred, from relevant health care professionals.
- That LauraLynn may share health related information with relevant health care professionals.
- That LauraLynn may retain health related information regarding the child being referred, in line with National Hospitals Office (NHO) Code of Practice for Healthcare Records Management, 2007.

I / We give permission for a referral for _____ to be made to LauraLynn, Children's Disability respite service.

Parent(s)/Guardian(s) Signature: _____ Date: _____

Parent(s)/Guardian(s) Signature: _____ Date: _____

Paediatrician Details

Name:

Address:

Eircode:

Telephone Number:

Email Address:

G.P. Details

Name:

Address:

Eircode:

Telephone Number:

Fax Number:

Primary Disability Service

Name:

Address:

Eircode:

Telephone Number:

Fax Number:

Child Information		
Diagnosis:		
Brief Summary of Child's Current Condition and Description of nursing care needs:		
Reason for Referral - How do you think LauraLynn Children's Disability Respite Services may best support this child and family?		
Family's understanding and expectations of placement (i.e. number and frequency of required respite dates, i.e. midweek/weekend/school holidays etc.,)		
Please complete:	Please delete:	Further information if relevant:
Independently mobile	Yes/No	
Hoisted for all transfers	Yes/No	
Epilepsy	Yes/No	
Enterally fed	Yes/No	
Sensory Impairments	Yes/No	
1:1 supervision	Yes/No	
Behavioural concerns	Yes/No	
PLEASE PROVIDE COPIES OF ANY ADDITIONAL INFORMATION/REPORTS THAT YOU FEEL MAY BE RELEVANT TO THIS REFERRAL		

Siblings/Significant Family Members			
Name	Male/Female	Date of Birth	Additional (Health) Needs
1.			
2.			
3.			
4.			
Professional Involvement – Health Care Professionals e.g. Disability Service, Public Health Nurse, Social Worker, Physiotherapist,			
Name	Title/Role	Telephone Number/Email Address	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
Additional Services involved in the care of child and family e.g. School, Nursing Agency, Neurology Team, Respiratory Team			
Organisation/Service Contact Person	Name of Lead Title / Role	Telephone Number/Email Address	
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Please complete and return to:

Anne-Marie Carroll, Director of Nursing
 Lauralynn, Ireland’s Children’s Hospice
 Children’s Sunshine Home, Leopardstown Road
 Foxrock,
 Dublin 18
 D18 X063

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E: acarroll@lauralynn.ie