CHILDREN'S DISABILITY RESPITE REFERRAL FORM

Child Details			
Child's Name:			
Address:	Eircode:		
Date of Birth:		Gender:	
Nationality:		Religion:	
First Language:		PPS Number:	
Current living at home circumstances:			
Are there any Child Protection concerns with this child and family?	Yes ☐ No ☐ Not known ☐		
For referrals from CHO6/East is Disability Supports Application Management Tool (DSAMT) attached? Yes ☐ No ☐	Date of application: _____ Reason: _____ _____		

Parents/Legal Guardians	
Name:	Name:
Relationship:	Relationship:
Legal Guardian: Yes ☐ No ☐	Legal Guardian: Yes ☐ No ☐
Address: As Above: ☐ Eircode: ☐	Address: As Above: ☐ Eircode: ☐
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/information about current supports and services received 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/information on services being provided with relevant health care professionals/service providers.
- 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:

Respite/Additional Service Provision

What other types of respite are availed of ? _____

_____

Total number of nights per month/per annum: _____

Please list any home support services availed of & number of hours per week:

_____

_____

Current school attended and hours per week:_____

Child Information

Diagnosis:	
Level of Intellectual Disability	Mild [ ] Moderate [ ] Severe/Profound [ ]
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	Relationship	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.			

Additional Relevant Information

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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Healthmail: CSHdisabilityservice@healthmail.ie
E: acarroll@lauralynn.ie