EARLY INTERVENTION SERVICES INTAKE FORUM
REFERRAL FORM

PERSONAL DETAILS

Child's Name	**Date of Birth**
Gender Male ☐ Female ☐	**Child's Age** Years Months
Address of child	**Does your child attend** Crèche ☐ Pre-school ☐ School ☐ N/A ☐ **Contact number:** _____
Mother's Name **Telephone**: Mobile Landline **Address** (if different from child's)	**Father's Name** **Telephone**: Mobile Landline **Address** (if different from child's)

Names of Legal Guardian(s) _____
(see page 8 for definition)
Who does the child live with _____

Siblings Name	Age	Involved in other services Yes	No	Details

REFERRAL INFORMATION

What are the main concerns regarding your child's development

1. _____
2. _____
3. _____

Has a diagnosis been made or a condition identified	Yes ☐ No ☐ Not Sure ☐
If yes what is the diagnosis/condition	
Are there or have there been other services involved with your child	Yes ☐ No ☐ Not Sure ☐
If yes please list	
What is the main language spoken in the home	
Do you require an interpreter	Yes ☐ No ☐ Not Sure ☐

BIRTH HISTORY

Length of pregnancy Weeks Days	Birth weight
Was your child admitted to the neonatal unit	Yes ☐ No ☐ Not Sure ☐
If yes please describe	
Has your child been in hospital since he/she was born	Yes ☐ No ☐
If yes for what reason	

EYESIGHT

Do you have concerns about your child's eyesight	Yes ☐ No ☐ Not Sure ☐
Has your child's eyesight been tested	Yes ☐ No ☐ Not Sure ☐
If yes what was the outcome	

HEARING

Do you have concerns about your child's hearing	Yes ☐ No ☐ Not Sure ☐
Has your child's hearing been tested	Yes ☐ No ☐ Not Sure ☐
If yes what was the outcome	

YOUR CHILD'S DEVELOPMENT

Please complete all sections

Note that some questions may not be relevant to your child

MOVEMENT

Has your child achieved the following (please tick ✓the appropriate box)

		If yes at what age	
Rolling from tummy to back	**Yes** ☐ **No** ☐		**Not Sure** ☐
Sitting without support	**Yes** ☐ **No** ☐		**Not Sure** ☐
Crawling (on all fours)	**Yes** ☐ **No** ☐		**Not Sure** ☐
Bottom Shuffling	**Yes** ☐ **No** ☐		**Not Sure** ☐
Pulling to stand	**Yes** ☐ **No** ☐		**Not Sure** ☐
Walking independently	**Yes** ☐ **No** ☐		**Not Sure** ☐
Running	**Yes** ☐ **No** ☐		**Not Sure** ☐
Jumping	**Yes** ☐ **No** ☐		**Not Sure** ☐

Manipulation of small objects (e.g. picking up raisins or pasta)	**Yes** ☐ **No** ☐ **Not Sure** ☐
Playing with constructional games (e.g. Jigsaw/Lego)	**Yes** ☐ **No** ☐ **Not Sure** ☐
Using a pencil/pen	**Yes** ☐ **No** ☐ **Not Sure** ☐
Cutting with scissors	**Yes** ☐ **No** ☐ **Not Sure** ☐

Do any of the following describe your child's movement

Trips a lot	**Yes** ☐ **No** ☐ **Not Sure** ☐
Falls a lot	**Yes** ☐ **No** ☐ **Not Sure** ☐
Tires easily	**Yes** ☐ **No** ☐ **Not Sure** ☐
Bumps into things a lot	**Yes** ☐ **No** ☐ **Not Sure** ☐
Always on the go	**Yes** ☐ **No** ☐ **Not Sure** ☐

Any further comments about your child's movement

DAILY LIVING SKILLS (Note that some questions may not be relevant to your child)	
Do you have concerns about your child's eating and drinking	Yes ☐ No ☐ Not Sure ☐
If yes please describe	
Is your child a fussy eater	Yes ☐ No ☐ Not Sure ☐
If yes please describe	
Can your child	
Use a cup independently	Yes ☐ No ☐ Not Sure ☐
Use a spoon independently	Yes ☐ No ☐ Not Sure ☐
Use a fork independently	Yes ☐ No ☐ Not Sure ☐
Undress independently	Yes ☐ No ☐ Not Sure ☐
Dress independently	Yes ☐ No ☐ Not Sure ☐
Is your child toilet trained by day	Yes ☐ No ☐ Age
Is your child toilet trained by night	Yes ☐ No ☐ Age
Do you have concerns about your child's sleep	Yes ☐ No ☐
If yes please describe	
Any further comments about your child's daily living skills	

SPEECH, LANGUAGE AND COMMUNICATION (Note that some questions may not be relevant to your child)	
Do you have concerns about your child's ability to communicate	Yes ☐ No ☐ Not Sure ☐
Does your child use gestures (e.g. wave bye bye and point)	Yes ☐ No ☐ Not Sure ☐
What age did your child say his/her first words	Age

Form revised and completed on 23 Feb. 11

Do any of the following describe your child's speech, language and communication ability	
My child has difficulty understanding what I say	**Yes** ☐ **No** ☐ **Not Sure** ☐
My child has difficulty expressing him/herself (e.g. the amount of words my child can say)	**Yes** ☐ **No** ☐ **Not Sure** ☐
My child has difficulty with speech (e.g. my child's speech is difficult to understand compared to other children)	**Yes** ☐ **No** ☐ **Not Sure** ☐
If yes to any of the above please describe	
Any further comments about your child's speech, language and communication	

BEHAVIOUR AND EMOTIONS
(Note that some questions may not be relevant to your child)

Do you have concerns about your child's behaviour	**Yes** ☐ **No** ☐ **Not Sure** ☐
Is your child's behaviour difficult to manage	**Yes** ☐ **No** ☐ **Not Sure** ☐
If yes please describe	

Do any of the following describe your child (please tick ✓ relevant boxes)

Frequent Tantrums	Aggressive	Irritable	Excessive crying	Upset for minor reasons
Withdrawn /too quiet	Doesn't like change	Clingy	Frustrated	Worries a lot

Any further comments about your child's behaviour and emotions

PLAY
(Note that some questions may not be relevant to your child)

Do any of the following describe your child's play

Prefers to play alone	**Yes** ☐ **No** ☐ **Not Sure** ☐
Prefers to play next to other children but not with them	**Yes** ☐ **No** ☐ **Not Sure** ☐

Prefers to play with other children	**Yes** ☐ **No** ☐ **Not Sure** ☐
Prefers to play with adults	**Yes** ☐ **No** ☐ **Not Sure** ☐
My child will take turns when playing with other children	**Yes** ☐ **No** ☐ **Not Sure** ☐
My child will share toys with other children	**Yes** ☐ **No** ☐ **Not Sure** ☐
My child shows an interest in other children	**Yes** ☐ **No** ☐ **Not Sure** ☐
What toys does your child prefer to play with	
What activities does your child like doing	
Any further comments about your child's play	

LEARNING **(Note that some questions may not be relevant to your child)**	
Do you have concerns about your child's ability to learn new skills	**Yes** ☐ **No** ☐ **Not Sure** ☐
If yes please describe	
Has anyone ever expressed concern about your child's ability to learn (e.g. pre-school teacher, PHN, GP, family member etc)	**Yes** ☐ **No** ☐ **Not Sure** ☐
If yes please give details	
Do you have concerns about your child's ability to concentrate	**Yes** ☐ **No** ☐ **Not Sure** ☐
If yes please give details	
Any further comments about your child's learning	

Additional Family Information you feel is relevant to your child's referral
Please comment

I/we also give consent to the Intake Forum or designated Early Intervention Services to contact and obtain relevant information from:		
PROFESSIONAL	**NAME**	**CONTACT DETAILS**
General Practitioner (GP)		
Public Health Nurse (PHN)		
Speech and Language therapist		
Psychologist		
Occupational therapist		
Physiotherapist		
Social worker		
Paediatrician		
Crèche/Preschool/School		
Audiologist (hearing)		
Ophthalmologist (vision)		
Assessment of need officer		
Other		

Definition of Legal Guardian of a child

- Where the child's parents are not married, the child's mother only.
- Where the child's parents are not married, the mother of the child & the child's father or any other named person when appointed guardian further to a successful court application for guardianship.
- Where both parents are married, the child's mother and father are legal guardians.
- Following a separation or divorce, both parents remain the child's legal guardian, even if the child is not living with them and they have not been awarded custody of the child.
- Where the children's parents are not married and the mother of the child and the child's father have entered into an agreement which has the effect of making the father the guardian of the child.

REFERRER'S DETAILS

This form was completed by

Mother	Yes ☐	No ☐	Father	Yes ☐	No ☐
Health Professional	Yes ☐	No ☐			

HEALTH PROFESSIONAL DETAILS

Name and profession _____

Phone Work _____ Mobile No. _____

Signature _____ Date completed _____

CONSENT

It is required by law that at least one of the child's legal guardian consents to the referral and signs this form. It is advisable that the parent(s)/guardian(s) are aware of this referral

I/we give permission for my/our child to be referred to the Early Intervention Service Intake Forum

Do you agree that in the event that this referral is not appropriate for the Early Intervention Service this referral form may be shared with other relevant services to facilitate an onward referral

Yes ☐ No ☐

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Please return all referral forms to: Clinical Link, North Lee Early Intervention Intake Forum, HSE South, 1st Floor, Blackpool (Adj. to Shopping Centre), Cork

ADDITIONAL INFORMATION IS ALWAYS USEFUL
PLEASE ATTACH IF AVAILABLE

FOR OFFICE USE ONLY

To be completed at Early Services Referral Forum meeting

Referral presented for discussion on ___/___/___

Referral was assigned to: _____

Signed: _____

(on behalf of Early Services Referral Forum meeting)

Form revised and completed on 23 Feb. 11