



Children’s Services Referral Form

All fields highlighted with an asterisk (*) are mandatory.

Please note that Adobe Acrobat software is required to use the Submit function on this form.

Who should use this form?

- Children aged from birth to 18 years may be referred by parents/legal guardians, health and social care professionals including General Practitioners, education professionals, Assessment Officers or Case Managers to Children’s Disability Network Teams, Primary Care Services or Child and Adolescent Mental Health Services (CAMHS).
- Referrals to Children’s Disability Network Teams must be accompanied by the Additional Information Form for the child’s age group, completed by the child’s parent(s)/legal guardian. Links to the Additional Information Forms are provided at the bottom of this Form.
- All referrals to Child and Adolescent Mental Health Services should be made in conjunction with the GP.

Please Note: Once the form is completed you must select the Submit button at the end of the form which will open up an email addressed to the Central Referrals Office and any additional information/reports can be attached at this stage if required. Please note that all fields marked *mandatory must be completed for the email to generate.

Date of Referral* Please use format DD/MM/YYYY

Services you wish to refer to*

Children’s Disability Services

Children with complex needs should be referred to their local Children’s Disability Network Team.

A child has complex needs if they have a range of significant difficulties that require the services and support of a disability team.

Children’s Disability Network Team

Primary Care Services

Children with non-complex needs should be referred to Primary Care services.

Dietetics (Health & Social Care Professional Referral only) <input type="checkbox"/>	Physiotherapy <input type="checkbox"/>
Speech & Language Therapy <input type="checkbox"/>	Occupational Therapy <input type="checkbox"/>
Social Work <input type="checkbox"/>	Psychology <input type="checkbox"/>
Nursing <input type="checkbox"/>	

Child and Adolescent Mental Health Services (CAMHS)

Children for whom comprehensive treatment at primary care level has been unsuccessful and who present with moderate to severe mental disorders should be referred to CAMHS.

Child and Adolescent Mental Health Services

Child's personal details

Surname*	<input type="text"/>	First Name*	<input type="text"/>
Gender*	<input type="text"/>	Other	<input type="text"/>
Date of Birth*	<input type="text"/>	IHI	<input type="text"/>
PPS Number*	<input type="text"/>	Medical Card Number	<input type="text"/>
Address Line 1*	<input type="text"/>		
Address Line 2*	<input type="text"/>		
Address Line 3	<input type="text"/>		
Mother's Maiden name *	<input type="text"/>		
County*	<input type="text"/>		
Eircode	<input type="text"/>		

Parent/Guardian (1)

Surname*	<input type="text"/>	First Name*	<input type="text"/>
Relationship to child*	<input type="text"/>		
Mobile/Phone* (Mobile preferred)	<input type="text"/>		
Email	<input type="text"/>		
Address Line 1*	<input type="text"/>		
Address Line 2*	<input type="text"/>		
Address Line 3	<input type="text"/>		
County*	<input type="text"/>		
Eircode	<input type="text"/>		

Parent/Guardian (2) if applicable

Surname	<input type="text"/>	First Name	<input type="text"/>
Relationship to child	<input type="text"/>		
Mobile/Phone	<input type="text"/>		
Email	<input type="text"/>		
Address Line 1	<input type="text"/>		
Address Line 2	<input type="text"/>		
Address Line 3	<input type="text"/>		
County	<input type="text"/>		
Eircode	<input type="text"/>		

Country of Birth	<input type="text"/>			
First Language*	<input type="text"/>	Other	<input type="text"/>	
Other languages spoken at home	<input type="text"/>			
Interpreter required*	Yes	<input type="radio"/>	No	<input type="radio"/>
Please specify language	<input type="text"/>			

Number of siblings, their ages and details of any services they are attending.

Referrer details

Surname*

First Name*

Source of Referral*

Other

Health Professional Registered No. (HPRN) e.g., NMBI/CORU/MRN

Address Line 1*

Address Line 2*

Address Line 3

County*

Eircode

Mobile/Phone*

Email*

Please indicate whether referrer should be contacted prior to the initial appointment: Yes

No

Are there any relevant risk factors in relation to this referral?

Reasons for referral*

What are the main concerns and priorities for the child and their family?

1

2

3

For Child and Adolescent Mental Health (CAMHS) referrals

What is the child/young person's current mental state?

Describe the presenting problems, symptoms, when did they start and other problems identified.

What risk and/or resilience factors are currently present?

General practitioner details

Are these details the same as those included in the Referrer Details section?

Yes

No

Surname*

First Name*

GP Practice*

GP Telephone*

Email

Address Line 1*

Address Line 2*

Address Line 3

County

Eircode

Other community healthcare services

Is your child currently waitlisted or receiving any other services?

Yes

No

Children's Disability Network Team

Primary Care

Dietetics

Physiotherapy

Speech & Language Therapy

Occupational Therapy

Social Work

Psychology

Community Medicine Service

Nursing

Other

(Please give details)

Child & Adolescent Mental Health Service (CAMHS)

Tusla – The Child and Family Agency

Other (Please give details)

Professionals and services your child has attended

Name (if available)	Service	Contact Details

Creche, preschool or school details

(Attach any Preschool or School Reports)

Creche/Preschool

Address (including Eircode)

Manager/Contact Person

Telephone

Email

School	<input type="text"/>
Child's Class	<input type="text"/>
Address (including Eircode)	<input type="text"/>
Principal's Name	<input type="text"/>
Telephone	<input type="text"/>
Email	<input type="text"/>

Medical history

(Please attach any relevant Medical Reports as per instructions at the top of the form)

Relevant Medical History & Birth History.

Any diagnosis e.g. medical condition, learning disability, developmental disorder, hearing impairment.
There may be more than one. Who made the diagnosis and date?

If the child is currently in hospital what date is he/she expected to be discharged?

Current medications – including dietary supplements.

Allergies/Adverse medication events.

Current investigations e.g. blood tests, scans, hearing tests.

Social circumstances

Relevant family and social history

For example family health or housing difficulties, financial or employment problems, bereavement or other stresses.

Any other relevant information

Consent

Referral Consent: Have the parent(s)/legal guardian(s) consented to this referral and has this been documented?

Yes No

Have the parent(s)/legal guardian(s) given permission to Primary Care Services/ Children's Disability Services/CAMHS to contact and obtain relevant information in order to understand and address the child's needs from the professionals and services listed below, such as a hospital consultant, psychologist, speech & language therapist, teacher etc. Only those listed on page 7 will be contacted.

Yes No

Have the parent(s)/legal guardian(s) given permission that in the event that this referral is not appropriate it may be shared with other relevant services to facilitate an onward referral.

Yes No

GDPR Consent: Have the parent(s)/legal guardian(s) given permission for information about the child to be held by Primary Care Services/Children's Disability Services/CAMHS in accordance with obligations under the Data Protection Acts 1988, 2003 and 2018.

Yes No

Children in Care

For children in voluntary care or on an interim order, the parents must provide consent and this consent should be documented.

For children subject to an interim or temporary care order, an application must be made to the District Court to allow the healthcare worker involved with the child's care to give consent and a copy of the District Court decision and the consent of the Tusla healthcare worker should be documented.

For children subject to a full care order, the consent is provided by a Tusla Child and Family Agency social worker and this consent should be documented.

Definition of a Legal Guardian

All mothers, whether they are married or unmarried, have automatic guardianship status in relation to their children, unless they give the child up for adoption. A father who is married to the mother of his child also has automatic guardianship rights in relation to that child. This applies even if the couple married after the birth of the child.

A father who is not married to the mother of his child does not have automatic guardianship rights in relation to that child. If the mother agrees for him to be legally appointed guardian, they must sign a joint statutory declaration. However an unmarried father is automatically a guardian if he has lived with the child's mother for 12 consecutive months after 18/1/2016, including at least 3 months with the mother and child following the child's birth.

Any other information you want to give us

Additional information forms

Please attach the relevant forms below to the email once the submit button is clicked and the email is generated.

[0 – 12 months](#) | [1 – 3 years](#) | [3 – 6 years](#) | [6 – 12 years](#) | [12 – 18 years](#)

Submit