Dublin South Early Intervention Team Referral Form

Personal Information:

Name: _____Date of birth: _____ Gender: _____

Address: _____

Preschool contact details:

_____

Referral agent contact details:

_____

Referral agent signature:

_____

Please sign to indicate that you have reviewed the information on this form and support a referral to the Dublin South Early Intervention Team.

Reason for referral:

_____

_____

_____

Parent/Guardian and Family Information:

Mother's Name:_____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

If your child is adopted or fostered please provide further information (e.g. dates/ country of origin etc) _____

_____

Brothers/sisters:

Name	Age	Details of any health services attended

Birth History:

Hospital: _____ Length of pregnancy: _____
Delivery e.g. section/ventouse: _____ Birth weight: _____

How was the pregnancy and delivery experience?

_____

Did mother or baby need any follow up or monitoring after the delivery?

_____

Developmental Information:

Please tick the skills that your child has achieved as relevant to each of the developmental areas which follow:

Gross Motor Skills: (please not the age/approximate age the child achieve these skills)

Rolls - tummy to back	☐	Rolls - back to tummy	☐
Sits without support	☐	Bottom shuffles	☐
Crawls	☐	Pulls to stand	☐
Walks independently	☐	Runs & jumps	☐

Does your child have any difficulty with coordination or balance (e.g. often bumps into objects or trips)? _____

_____

Other relevant information: _____

_____

Fine Motor Skills:

Grasps small objects	☐	Uses two hands in play	☐
Uses pen/pencil	☐	Uses a scissors	☐

Other relevant information: _____

_____

Independence Skills: (please not the age/approximate age the child achieve these skills)

Holds bottle to drink	☐	Holds cup to drink	☐
Feeds self using a spoon	☐	Feeds self using a fork	☐
Dresses self without help	☐	Toilet trained day	☐
Toilet trained by night	☐		

Other relevant information: _____

_____

Speech/Language & Communication Skills: (please not the age/approximate age the child achieve these skills)

Responds to sounds or voices	☐	Responds to name	☐
Uses gestures & pointing	☐	Follows simple requests	☐

How many words does your child typically use when speaking (e.g. single words, 2 words utterances, short sentences etc)?

_____

_____

Does your child have any difficulty in speaking (e.g. hoarse voice, repeating or getting stuck on words, pronunciation etc)?

_____

_____

Does your child use any sign language or communication aid (e.g. LAMH, PECS etc)? _____

What languages are spoken at home?_____

Other relevant information:

_____

_____

Social and emotional development:

Smiles & looks at caregiver	☐	Easy sleeping/feeding patterns	☐
Plays alone with adult nearby	☐	Plays with other children	☐
Accepts changes in routines	☐	Follows home/preschool rules	☐

What are your child's favourite toys and activities?

_____

Other relevant information:_____

_____

Cognitive development:

Do you have any concerns around your child's attention and/or concentration?

_____

Is your child able to remain focused on tasks until completed?

_____

Do you have any concerns in relation to your child's learning?

_____

Other relevant information: _____

Medical Information:

GP contact details:

_____

Has your child any current or previous medical needs (e.g. hospitalisations, medications, recurrent infections etc)?

_____

_____

How is your child's hearing and vision? Have these areas been tested?

_____

Has your child attended or been referred to any other health services (e.g. Lucena Clinic, Community Social Work/Speech & Language Therapy etc)? Please indicate your consent for contact and liaison by signing the relevant box.

Service	Contact Person (if known)	Report Included (√ or X)	Permission to Contact? (parent please sign below to indicate consent)

Consent to referral:

I consent to the referral of my child to the HSE Dublin south Early Intervention Team.

Signed, _____ Signed, _____

Parent/Guardian Parent/Guardian

Date: _____ Date: _____

Are both parents aware of this referral? Yes ☐ **No** ☐

Please return the completed form with parent(s) and referrer's signatures to:

Referral Coordinator, HSE, Computer House, 66 Patrick Street, Dun Laoghaire, Co. Dublin, A96 Y074