

St. Gabriel’s Children’s Respite

Referral Form

**Please attach a recent photograph of your child with this referral**

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| **Key Information**  |
| Child’s Name: |  |
| Address:Please include Eircode |  |
| Date of Birth: | Gender: |
| Nationality: | Religion: |
| First Language: | Medical Card Number: |
| Are there any Child Safeguarding concerns or contact with Tusla with this child and family? Yes ☐ No ☐ Not known ☐ | Allergies:  |
| **Parents/Legal Guardians** |
| Name: (Primary contact for communication) | Name: (Second contact for communication) |
| Relationship:Legal Guardian: Yes ☐ No ☐ | Relationship: Legal Guardian: Yes ☐ No ☐ |
| Contact details (phone & email): | Contact details (phone and email).  |
| Address: **If different to above\*** | Address: **If different to above\*** |

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| **Please provide contact details in the case of an emergency in the event that parents/guardians cannot be contacted** |
| Name: |
| Relationship to Child: |
| Address: |
| Telephone Number: |
| Email/Other: |
| **Referrers Details** |
| Name: |
| Relationship to Child: |
| Address: |
| Telephone Number: |
| Email/Other: |
| Referrer’s Signature: | Date: |
| **Parent/Guardian Consent** |
| **Parent/Guardian permission is required to make a referral to St. Gabriel’s Children’s Respite House:**By signing below, you consent to the following:• That health related information regarding the child being referred, may be shared with, and given to St. Gabriel’s Children’s Respite Service.• That St. Gabriel’s may seek additional health related information and reports regarding the child being  referred, from relevant health care professionals.• That St. Gabriel’s may share health related information with relevant health care professionals.• That St. Gabriel’s 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 St. Gabriel’s Children’s Respite Service.Parent(s)/Guardian(s) Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent(s)/Guardian(s) Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Healthcare Professional Details**  |
| **Paediatrician Details** |
| Name: |
| Address whereby the child routinely attends his/her paediatric service:  |
| Telephone Number: |
| Email Address & Fax Number: |
| **Any other Consultants routinely involved in the child’s care** |
| Name: |
| Address whereby the child routinely attends his/her service:  |
| Telephone Number: |
| Email Address & Fax Number: |

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| **Any other Consultants routinely involved in the child’s care** |
| Name: |
| Address whereby the child routinely attends his/her service:  |
| Telephone Number: |
| Email Address & Fax Number: |
| **Any other Consultants routinely involved in the child’s care** |
| Name: |
| Address whereby the child routinely attends his/her service:  |
| Telephone Number: |
| Email Address & Fax Number: |

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| **GP** |
| Name: |
| Address: Eircode: |
| Telephone Number: |
| GP Fax Number / email address:  |

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| **Primary Disability Service** |
| Name: |
| Address: Eircode: |
| Telephone Number: |
| Fax Number: |

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| **Child’s Information** |
| Diagnosis: |  |
| Brief Summary of Child’s Current Condition and Description of specific nursing care needs: |  |
| Reason for ReferralHow do you think St. Gabriel’s 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 detail any in home supports that you are availing of currently |  |

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| **Please complete:** | **Circle as Appropriate** | **Further information if relevant:** |
| Independently mobile.If no please detail | Yes No |  |
| Uses Hoist for all transfers | Yes No |  |
| Diagnosis of Epilepsy: Please detail type and frequency of seizures | Yes No |  |
| Child receives nutrition via Enteral tube | Yes No |  |
| Diagnosis of Additional Sensory Impairments | Yes No |  |
| Does child require 1:1 supervision?If yes please detail. | Yes No |  |
| Behavioural concerns or supports required.  | Yes No |  |

**Please return completed forms to:**

Elaine O’Riordan

Respite House Manager, PIC

St. Gabriel’s Children’s Respite House

Moneteen

Mungret

Limerick V94 59R9

Email: eoriordan@stgabriels.ie

Mob 086 0759397

Respite House 061-302642