

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 Referral  How 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](mailto:eoriordan@stgabriels.ie)

Mob 086 0759397

Respite House 061-302642