West Cork Child Development Services
Working together to support children and families

CoAction

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Referral Form Early Intervention
West Cork Child Development Services

Please complete every section of the form and sign it.
Please refer to service information leaflet prior to completing an application
Please attach relevant reports with this referral

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 and name____________________
Mother's Name **Telephone:** Mobile: Landline: Email Address: **Address:** (If different from child's) ______________________________ ______________________________ ______________________________	**Father's Name** **Telephone:** Mobile: Landline: Email Address: **Address:** (If different from child's) ______________________________ ______________________________ ______________________________

Names of Legal Guardian(s): ____________________________________
(see page 6 for definition)

Who does the child live with? ____________________________________

What is the main language spoken in the home?________________________
Do you require an interpreter? Yes ☐ No ☐

Sibling's Name	Age	Involved in other Services		Details
		Yes	No	

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, please state diagnosis/condition, when and by whom: ____________________________

____

Current /pending investigations/appointments / __________________________________

Developmental History:

BIRTH HISTORY:

Length of pregnancy: _________Birth weight: _________

Please give any relevant details regarding your child's birth:

MEDICAL HISTORY:

1. Has your child been in hospital since they were born? Please give details:

____

____

---

2. Other relevant medical history: e.g. epilepsy, diabetes, heart condition:

____

____

---

3. Is your child taking any regular medicines? Please give details:

____

____

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, please give details:

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, please give details:

MOVEMENT/FINE MOTOR

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 ☐
Can your child manipulate small objects (e.g. picking up raisins or pasta)	Yes ☐	No ☐		Not Sure ☐
Does your child construct games (e.g. Jigsaw/Lego)	Yes ☐	No ☐		Not Sure ☐
Can your child use a pencil/pen	Yes ☐	No ☐		Not Sure ☐
Can your child use scissors	Yes ☐	No ☐		Not Sure ☐

Do any of the following describe your child's movements

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

Any further comments about your child's movement:

SENSORY

Is your child over or under-sensitive to daily life sensations? e.g. hates sound of hoover, avoids certain textures, gets easily over-stimulated, etc. Please give details:

Does your child dislike having a bath or shower?	Yes ☐	No ☐	Not Sure ☐
Does your child dislike getting dressed or changed?	Yes ☐	No ☐	Not Sure ☐
Does your child dislike getting his/her hair washed/cut?	Yes ☐	No ☐	Not Sure ☐
Is your child sensitive to certain noises?	Yes ☐	No ☐	Not Sure ☐

Any further comments about your child's sensory issues:

SPEECH AND LANGUAGE / COMMUNICATION

Has your child achieved the following, if yes at what age?:

Babbling:	Yes ☐	No ☐	Not Yet ☐	Age ☐
Use gestures (e.g. wave bye-bye and point):	Yes ☐	No ☐	Not Yet ☐	Age ☐
Use words	Yes ☐	No ☐	Not Yet ☐	Age ☐
Use short sentences	Yes ☐	No ☐	Not Yet ☐	Age ☐

Does your child have difficulty understanding what you say?	Yes ☐	No ☐	Not Sure ☐
Does your child have difficulty making sentences?	Yes ☐	No ☐	Not Sure ☐
Is your child's speech difficult to understand?	Yes ☐	No ☐	Not Sure ☐

If yes to any of the above, please describe:

Any further comments about your child's speech, language and communication:

DAILY LIVING SKILLS

Do you have concerns about your child's eating and drinking?	Yes ☐	No ☐

If yes, please describe:

Does your child use a cup/beaker independently?	Yes ☐	No ☐	Not Sure ☐	
Does your child use a spoon independently?	Yes ☐	No ☐	Not Sure ☐	
Does your child use a fork independently?	Yes ☐	No ☐	Not Sure ☐	
Does your child undress independently?	Yes ☐	No ☐	Not Sure ☐	
Does your child dress independently?	Yes ☐	No ☐	Not Sure ☐	
Is your child toilet trained by day?	Yes ☐	No ☐	At what Age ☐	Not Sure ☐
Is your child toilet trained by night?	Yes ☐	No ☐	At what Age ☐	Not Sure ☐
Do you have concerns about your child's sleep?	Yes ☐	No ☐	Not Sure ☐	

If yes to any of the above, please describe:

Any further comments about your child's daily living skills:

BEHAVIOUR AND EMOTIONS

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 AND SOCIAL DEVELOPMENT

Prefers to play alone	Yes ☐	No ☐	Not Sure ☐
Plays next to other children, but not with them	Yes ☐	No ☐	Not Sure ☐
Plays with other children	Yes ☐	No ☐	Not Sure ☐
Takes turns when playing	Yes ☐	No ☐	Not Sure ☐
Shares toys with other children	Yes ☐	No ☐	Not Sure ☐
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/concerns about your child's play and social development

LEARNING

Do you have concerns about your child's ability to learn new skills?	Yes ☐	No ☐	Not Sure ☐

If Yes, please describe

Do you have concerns about your child's ability to learn new skills?

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 describe

Do you have concerns about your child's concentration?	Yes ☐	No ☐	Not Sure ☐

Additional relevant information about your child's strengths and needs

(Use extra sheets if required).

Please include how any difficulties experienced by your child impact on everyday tasks, learning, play and on your child's ability to make their needs known or to have their needs met.

West Cork Child Development Services
Working together to support children and families

This form was completed by: (please tick)

Mother: ☐ Yes ☐ No Father: ☐ Yes ☐ No

Health Professional: ☐ Yes ☐ No Other (e.g. guardian): ☐ Yes ☐ No

Health professional details:

Name and profession:	
Phone Number:	Mobile:
Signature:	Date:

I/we ______________________________ also give consent to the Early Intervention Services to contact and obtain relevant information from:

Professional	Name	Contact Details
General Practitioner (GP)		
Public Health Nurse (PHN)		
Speech & Language Therapist		
Psychologist		
Occupational Therapist		
Physiotherapist		
Social Worker		
Paediatrician		
Crèche/Pre-school/School		
Audiologist (hearing)		
Ophthalmologist (vision)		
Assessment of Need Officer		
CAMHS		
Dietician		
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 and 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.
- I/We consent to referral to the Early Intervention Team

Signature/s ____________________________ ________________________________

Date:________________________

Please return completed forms to:

Hazel Trudgill, Services Manager, West Cork Child Development Services,

Children's Services Centre, St. Mary's Road, Dunmanway, Co. Cork.