Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

# ADDITIONAL INFORMATION FORM TO ACCOMPANY CHILDREN'S SERVICES REFERRAL FORM

## Child/young person aged from 12 years to 17 years 11 months

**Date of Referral:** **Referrer:**

**In order to help services appropriately accept and prioritize referrals, this form should be completed by the child's parents or in consultation with them, and sent with the Children's Services Referral Form.**
**Please also enclose copies of any health or school reports you have**

| Child's or Young Person's Surname | First Name | Date of Birth |
|---|---|---|
| | | |

**Parents' names and contact details**

**YOUR CHILD'S OR YOUNG PERSON'S DEVELOPMENT** Please note some questions may not be relevant

### 1. Movement (Gross Motor Skills)

Do you have any concerns about your child's or young person's ability to move around such as walking, running, jumping, and balancing? Yes ☐ No ☐
If Yes give details including any assistance required such as crutches, wheelchair for distance:

How does their difficulty with moving impact on their ability to do everyday tasks e.g. leisure and social activities, washing, dressing?

Have you noticed any recent changes in their ability to move or their level of fatigue? Yes ☐ No ☐
If Yes, please give details:

Do you have any other concerns about their movement or gross motor skills?

### 2. Fine Motor and Hand Skills

Does your child or young person have difficulty using their hands such as handwriting, using scissors, picking up small items, using computers? Yes ☐ No ☐
If yes, give details:

### 3. Communication

Does your child or young person have difficulty expressing themselves e.g. asking for help, describing events?
Yes ☐ No ☐

Do they have difficulty understanding people? Yes ☐ No ☐

Is it difficult to understand what they are saying? Yes ☐ No ☐

Do they have difficulty going along with a conversation if the other person changes the topic? Yes ☐ No ☐

Do they have any difficulty with understanding jokes or phrases such as 'I'm only pulling your leg'? Yes ☐ No ☐

**If Yes to any of the above questions please describe:**

Do they use technology or a computer to communicate? Yes ☐ No ☐
If yes please give further information on technology or computer use:

Do they have any issues with their voice e.g. prolonged hoarseness?

Do you have any other concerns about their speech, language, communication and voice?

## 4. Social Interaction, Relationships and Leisure

Do you have concerns about your child's or young person's ability to form and keep up relationships with others?
Yes ☐ No ☐
Please describe your concerns:

Please describe any leisure or sport activities they take part in:

## 5. Daily Living Skills

### 5A. Food and Drink

Do you have any concerns about your child's or young person's weight or growth? Yes ☐ No ☐
If Yes, give details:

Do you have any concerns about how much food they eat or the range of foods they eat? Yes ☐ No ☐
If Yes, give details:

Describe their daily food, drinks and mealtime routine:

Do you have any concerns about *how* they are eating drinking or swallowing?
If yes please describe

Are mealtimes stressful? Yes ☐ No ☐
If Yes, describe:

Are they on specialised drinks or foods? Yes ☐ No ☐
If Yes, give details:

## 5B. Bowel and Urinary Habits (Continence)

Are there any difficulties with toileting? Yes ☐ No ☐
If Yes, give details:

## 5C. Personal Care, Dressing and Independence

Do you have concerns about your child's or young person's ability to manage the following compared with others their age?

| | | | | | |
|---|---|---|---|---|---|
| Dressing | Yes ☐ | No ☐ | Undressing | Yes ☐ | No ☐ |
| Washing | Yes ☐ | No ☐ | Brushing teeth | Yes ☐ | No ☐ |
| Organising belongings | Yes ☐ | No ☐ | Getting ready for school | Yes ☐ | No ☐ |
| Getting ready for bed | Yes ☐ | No ☐ | | | |

If Yes to any of the above give details:

## 5D. Sleep and Rest

Do you have concerns about their sleep or ability to rest or relax? Yes ☐ No ☐

Do they have difficulty initiating activities or appear lethargic or tire easily? Yes ☐ No ☐
If Yes, give details:

## 6. Behaviour and Emotions.

Have you concerns about your child's or young person's emotional wellbeing and behaviour?
At home ☐ At school ☐ Out and about ☐
Please describe any concerns

**Do the following statements describe their behaviour and emotions? (Please tick the appropriate boxes)**

| | | | | |
|---|---|---|---|---|
| Frequent prolonged outbursts or meltdowns ☐ | Aggressive ☐ | Avoids certain activities or people ☐ | Low mood ☐ | Clingy ☐ |
| Upset for seemingly minor things ☐ | Withdrawn/too quiet ☐ | Doesn't like change ☐ | Frustrated ☐ | Worries a lot ☐ |

If Yes to any of the above, how often does this occur? Daily ☐ Weekly ☐ Monthly ☐ Less often ☐
What impact does this have on them and on your family and what helps to prevent problems?

## 7. Learning

Do you have any concerns about your child's or young person's ability to learn? Yes ☐ No ☐
If Yes give details:

Has anyone expressed any concern about their ability to learn such as a teacher, psychologist or family member?
Yes ☐ No ☐
If Yes give details of the concern and who expressed it:

Are they having any difficulties keeping up with learning and school work? Yes ☐ No ☐
If yes please give details:

Have they had any assessments e.g. NEPS?

***Please enclose with this form copies of any school or psychology reports you have on your child.***

Do they have extra learning support in school such as SNA, Special Education teaching? Yes ☐ No ☐
If Yes give details

## 8. Vision and Hearing

Does your child or young person have problems with eyesight or vision which cannot be corrected with glasses?
Yes ☐ No ☐
If Yes, give details:

Do they attend a specialist service for their vision or hearing? Yes ☐ No ☐
If Yes, give details:

## 9. Sensory Processing

**If you have concerns about your child's or young person's sensitivity to any of the following, either avoiding, getting annoyed with or seeking out, please tick:**
Noise ☐ Touch ☐ Textures (such as fabrics) ☐ Movements ☐ Smells ☐ Food ☐ Lights ☐

If you have ticked any of the above, please describe how this impacts on everyday life for your child and for you :

| Is there anything else you would like to tell us? |
| --- |
| **Tell us what your child or young person enjoys and can do well as well as those things they find difficult** |
| **What is your main concern and priority?** |

| Safety and Risk |
| --- |
| **Are there any issues which are a significant risk to their health and wellbeing or that of others, such as physical injury to self or others, refusal to eat?** |

| Please give details of who completed this form |
| --- |
| **Form completed by:**<br><br>**Relationship to child:**<br><br>**Contact details:**<br><br>**Date:** |

**N.B. Please attach copies of any relevant health or school reports you have on your child.**