

## St John of God Liffey Early Services Preschool Referral Form

Personal Information			
<b>Name of Child:</b>		<b>Sex:</b>	
<b>Date of Application:</b>		<b>Application Completed by :</b>	
<b>PPSN:</b>		<b>Relationship to the child:</b>	
<b>Child's Diagnosis (if any)</b>		<b>Current Preschool Location: (if applicable)</b>	<b>Name:</b> <b>Address:</b> <b>Days Enrolled:</b>
<b>Which Children's Disability Network Team (CDNT) is the Child linked to :</b>	<div style="text-align: right; margin-bottom: 5px;"><input checked="" type="checkbox"/> Tick one</div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>CDNT 1 <input type="checkbox"/></p> <p>CDNT 2 <input type="checkbox"/></p> <p>CDNT 3 <input type="checkbox"/></p> <p>CDNT 4 <input type="checkbox"/></p> <p>CDNT 5 <input type="checkbox"/></p> </div> <div style="width: 45%;"> <p>CDNT 6 <input type="checkbox"/></p> <p>CDNT 7 <input type="checkbox"/></p> <p>CDNT 8 <input type="checkbox"/></p> <p>Not linked to a CDNT <input type="checkbox"/></p> </div> </div>	<b>Are you in receipt of Services from the CDNT?</b>	<div style="text-align: right; margin-bottom: 5px;"><input checked="" type="checkbox"/> Tick one</div> <p>Yes <input type="checkbox"/>      No <input type="checkbox"/></p> <p>If Yes please list (eg. Speech &amp; Language):</p>
<b>Consent: Do you give St John of God's Liffey Early Services permission to contact the child's CDNT to discuss this referral if required?</b>			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Address of Child:</b>			
<b>Language Spoken At Home:</b>			
<b>Mothers Name:</b>		<b>Fathers Name:</b>	
<b>Mothers Address:</b>		<b>Fathers Address:</b>	

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<b>Mothers Contact no.:</b>	Work: Home:	<b>Fathers Contact no.:</b>	Work: Home:
<b>Mothers Email:</b>		<b>Fathers Email:</b>	
<b>Guardians Name:</b> <i>(if different to parents)</i>		<b>Emergency Contact Name</b> <i>(contact person if parents or guardian not available)</i>	
<b>Guardians Address:</b>		<b>Emergency Contact no.:</b>	Work: Home:
<b>Guardians Contact no.:</b>	Work: Home:		
<b>Guardians Email:</b>			

### Identifying the Child's Needs

*(Please refer to Appendix 1 Guidance Document when completing same)*

**Child's Name:**

**D.O.B:**

*Range and extent of child's functional difficulties and medical needs  
(put one tick only for each row).*

	No difficulty	Some difficulty	Significant difficulty	Highly significant difficulty	Please Provide Further Details
Area of function and participation (see explanatory guide to assist with decisions on referral)					

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Movement (gross motor skills: sitting, standing, walking, running & jumping)						
Fine Motor Skills (co-ordination of small muscles in movement with the eyes, hands & fingers eg. Grasping objects, picking up food/spoon to feed).						
Communication						Please specify how the child communicates: Verbal <input type="checkbox"/> Lamh <input type="checkbox"/> Other <input type="checkbox"/> Description:
Area of function and participation (see explanatory guide to assist with decisions on referral)	No difficulty	Some difficulty	Significant difficulty	Highly significant difficulty	Please Provide Further Details	
Daily Living Skills: Washing & Dressing						
Daily Living Skills: Feeding						Dysphagia: does the child have Eating and Drinking Dysphagia Guidelines in place? Yes <input type="checkbox"/> No <input type="checkbox"/>
Daily Living Skills: Toileting	I am toilet trained	I am in the process of toilet training	I wear a nappy at night time	I wear a nappy 24hrs		
Behaviour & Emotions						

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	<b>Learning &amp; Applying Knowledge and Skills</b>					
	<b>Vision &amp; Hearing</b>					I wear glasses: Yes <input type="checkbox"/> No <input type="checkbox"/>  I use a hearing aid: Yes <input type="checkbox"/> No <input type="checkbox"/>
	<b>Sensory Processing</b>					
	<b>Area of function and participation (see explanatory guide to assist with decisions on referral)</b>	<b>No difficulty</b>	<b>Some difficulty</b>	<b>Significant difficulty</b>	<b>Highly significant difficulty</b>	<b>Please Provide Further Details</b>
	<b>Medical Needs</b>					I have a diagnosis of Epilepsy: Yes <input type="checkbox"/> No <input type="checkbox"/>  I have allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> Description: _____ _____  I take regular medication Yes <input type="checkbox"/> No <input type="checkbox"/>  List of medication I take _____ _____  Other Medical Needs, description: _____ _____ _____
Please provide any additional information that may be relevant to this application:						

## St John of God Liffey Early Services Preschool Referral Form

**Referrals should be returned alongside a copy of a report/letter confirming diagnosis, via post or email to:**  
Aoife O'Donnell, St John of God Liffey Early Services, Unit 15 Block A, Gleann na hEorna, Cookstown, Tallaght. D24AD62 or  
Aoife.odonnell@sjog.ie

### Appendix 1 Guidance Document : Definitions

The following definitions should be interpreted in the context of cultural variations and norms that may exist for individual children and their families/communities.

**1. Gross motor skills** refers to the physical abilities of the person, for example, to access their environment and participate in activities that require whole body movements or movements involving the large muscles of the body.

These would include fundamental movement skills; such as walking, kicking, throwing, catching, maintaining balance, and jumping. It also involves the person's ability to learn new motor skills or improve upon basic motor abilities.

**2. Fine motor skills** refer to actions involving the small muscles of the hands, wrists and fingers and the coordination of hand and eye movements. They include smaller actions such as picking up objects between the thumb and finger, playing, holding a fork to eat, using a pencil to write carefully and communicating using gestures or signs.

**3. Daily Living skills (Activities of Daily Living)** refer to those skills required to do everyday tasks such as feeding ourselves, bathing, dressing, grooming, playing, doing school work and taking part in leisure activities.

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**4. Communication** refers to the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems. Good communication skills are essential to support learning and to develop and maintain social relationships.

### **5. Behaviour and Emotions**

Behaviour refers to the child's observable actions and reactions/responses in various environments

Emotions refer to the child's ability to express (verbally or non-verbally) and recognise, label and regulate the expression of internal states, e.g. joy, sadness, anger.

### **6. Social interactions and Relationships, Play and Leisure**

Social interaction and relationships refer to the child's ability to interact and relate with children and adults, by verbal or non-verbal means.

Play and leisure refers to solitary or interactive games or activities engaged in for enjoyment, including play with objects, social play, pretend play and imaginative play.

**7. Learning & applying knowledge and skills** refers to the child's ability to gain knowledge or skills by experience, practice or teaching and the ability to retain and access this information when required.

**8. Eyesight and Hearing**

Hearing refers to the ability to perceive sound and involves the detection, recognition, discrimination, comprehension and perception of auditory information.

Eyesight refers to four levels of visual functioning according to the International Classification of Diseases

1. Normal vision.
2. Moderate visual impairment.
3. Severe visual impairment.
4. Blindness.

Moderate visual impairment and severe visual impairment are grouped under the term low vision. Low vision together with blindness represents all visual impairment.

**9. Sensory Processing** refers to the process of taking in information from the world and from within our own bodies, making sense of that information, thus making it possible to use the body effectively within the environment.

**10. Medical need** refers to an impairment or limiting condition that requires medical or nursing management and/or use of specialised services. The condition may be congenital, developmental or acquired through disease or trauma and places restrictions in daily living.

**Definitions for Levels of Difficulty**

**No difficulty**

Within the domain under consideration the child is able to participate and function within a typical / age appropriate range.

**Some difficulties**

This refers to functional difficulties which:

- Result in restrictions in participation in one or more settings (home, school and community).
- Likely to be mitigated by short-term intervention and/or ongoing low level support or strategies.

The child:

- Experiences mild difficulties in participating in social, educational, family daily activities.
- Needs little assistance to choose, initiate and engage in activities.

**Significant difficulties**

This refers to functional difficulties which:

- result in the child's ability to perform in this area being delayed or different from peers and
- result in restrictions in participation in most settings (home, school and community) and
- negatively impact performance across some other areas of function and participation.

The child:-

- Experiences moderate difficulties in participating in social, educational, family and daily activities.
- Needs moderate assistance to choose, initiate and engage in activities.

**Highly significant difficulties**

This refers to functional difficulties which:

- result in the child's ability to perform in this area being markedly delayed or markedly different from peers and
- result in restrictions in participation in all settings (home, school and community) and
- negatively impact performance across multiple other areas of function and participation.

The child:-

- Experiences severe difficulties in participating in social, educational, family and daily activities.

Requires maximum assistance to choose, initiate and engage in activities.