Feidhmeannas Seirbhíse Sláinte
Health Service Executive

St Vincent's Hospital, Fairview
Founded in 1857

Please complete referral form in full

Dublin North Central Rehabilitation / Placement Referral Form

.

Name:	**Date of Birth:**
Address:	**G.P. Name & Address**
Telephone:	**CMHN:**
Consultant:	**Clinic:**
Social Worker	**Public Health Nurse:**
Referral Agent:	**Date Referral Completed:**

Medical Card No.:	Social Welfare No.
Travel Pass No.	Does client use public transport? Yes ☐ No ☐
Finance:	
Unemployment:	€ Per Week
Disability Allowance	€ Per Week
Other	€ Per Week

Reason for Referral:

Other Agencies/Professional involved in care: (Please attach all relevant reports e.g. most recent case summary, OT assessment etc)
Brief Psychiatric History including Diagnosis:
Current Mental State:
Current Medication including Compliance & History of Non Compliance:
Physical Illness/ Disabilities of Relevance (i.e. mobility, epilepsy, cardiac or respiratory, allergies, special dietary needs):
Investigations completed within the last year and results (e.g. Blood, Neuro imaging, EEG)
Brief description of family/partner/children and living circumstances:
Social or other supports:

Has the person formerly lived in a Community Residence? **Yes ☐ No ☐** **Specify Facility:** **Date & Duration of Placement:** **If unsuccessful, why?**
What other applications have been made for accommodation (i.e. Local Housing Authority/ Private Accommodation etc)**:**
History of Drug / Alcohol Abuse: **Yes ☐ No ☐**
Is the person aware of the referral? **Yes ☐ No ☐** **If not please give reason.**
Client View/ Needs(personal goals the client wants to address):
Carers View/ Needs(include views on service user/ relative and supports they may need):
Tick List Check : Referral Form ☐ Face Profile ☐ Face Risk Profile ☐ Case Summary ☐ Any additional relevant reports ☐

I have discussed the referral with the client:

Signature: _____

Date: _____