Feidhmeannas Seirbhíse Sláinte
Health Service Executive

St. Vincent's Hospital, Fairview,
Rehabilitation Day Service
Dublin North Central

AREA 7 DAY SERVICE REFERRAL FORM

Name: _____ Date of Birth: / /

Address: _____ Consultant: _____

_____ Key Worker: _____

_____ Contact Details: _____

Sector: _____

Telephone: _____ GP: _____

Ph: _____

Gender: _____ MRN No.: _____

PPS No: _____ Medical Card No: _____

Next of Kin/Significant other:_____

Relationship to Client: _____Telephone: _____

Has the client ever attended any day service before?

If yes, where? _____

Other Agencies/Professionals involved in care (i.e. Social Work):

_____

_____

Are there any reports completed that may be of relevance to the clients care in the Day Service? (if so please include a copy with referral)

_____

_____

Diagnosis and brief psychiatric history:

_____

_____

_____

_____

_____

_____

What mental health problems is the client currently experiencing? _____

_____

_____

_____

_____

_____

Risk (please include any relevant reports):

_____

_____

Current Medications:

_____

_____

_____

_____

Medical History (i.e.: epilepsy, cardiac or respiratory, drug allergies, diabetes):

_____

_____

_____

_____

Current Social Circumstances and Supports (i.e. relationships, living arrangements):

_____

_____

_____

_____

Family History:

_____

_____

_____

_____

Source of Income:

_____

_____

Does the client have literacy needs? YES NO

_____

_____

_____

Work / Training History:

_____

_____

_____

_____

Is the client aware of this referral? Yes/ No.

If no, Why not? _____

What would the client like to achieve by coming to the Day service?

_____

_____

_____

Referrer's Expectations of Service:

_____

_____

_____

Any additional information: (e.g. do they hold a bus pass?)

_____

_____

_____

Please Include The Following With The Referral:

Referral Form Completed	Yes / No
Case Summary Included	Yes / No
Risk Assessment Included	Yes / No
Recent Investigations/ Relevant Reports	Yes / No

Client signature: _____Date:_____

Referrer's name: _____ Signed: _____

Address: _____ Ph.No._____

Referral Guidelines:

Clients must be aware of referral.

Clients must be willing to attend structured group sessions.

Clients must be able to travel independently to day service.

Case summary to be included.

Risk assessment to be included.

Referral form to be completed in full.

Date referral received: _____

Date letter sent: _____

Date of initial assessment: _____

Signature: _____

Discharge Details:

Discharge date: _____

Discharged to: _____

Signature: _____