LauraLynn
IRELAND'S CHILDREN'S HOSPICE

REFERRAL FORM

Child Details

Child's Name:			
Address: Eircode:			
Date of Birth:		Gender:	
Nationality:		Religion:	
First Language:		PPS Number:	
Are there any Child Protection concerns with this child and family?		Yes ☐ No ☐ Not known ☐	

Parents/Legal Guardians

Name:	Name:
Relationship:	Relationship:
Legal Guardian: Yes ☐ No ☐	Legal Guardian: Yes ☐ No ☐
Address: As Above: ☐ Eircode: ☐	Address: As Above: ☐ Eircode: ☐
Home Phone No:	Home Phone No:
Mobile:	Mobile:
Email:	Email:

Referrer Details

Name of Referrer:	
Relationship to Child:	
Address: Eircode:	
Telephone Number:	
Email/Other:	
Referrer's Signature:	Date:

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Parent/Guardian Consent

Parent/Guardian permission is required to make a referral to LauraLynn:

By signing below, you consent to the following:

- That health related information regarding the child being referred, may be shared with, and given to LauraLynn, Ireland's Children's Hospice (LauraLynn).
- That LauraLynn may seek additional health related information and reports regarding the child being referred, from relevant health care professionals.
- That LauraLynn may share health related information with relevant health care professionals.
- That LauraLynn may retain health related information regarding the child being referred, in line with National Hospitals Office (NHO) Code of Practice for Healthcare Records Management, 2007.

I / We give permission for a referral for _____
to be made to Lauralynn, Ireland's Children' Hospice.

Parent(s)/Guardian(s) Signature: _____ Date: _____

Parent(s)/Guardian(s) Signature: _____ Date: _____

Paediatrician Details

Name:

Address:

Eircode:

Telephone Number:

Email Address:

G.P. Details

Name:

Address:

Eircode:

Telephone Number:

Fax Number:

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Medical Details – To be completed by Paediatrician

Urgency of Referral	Routine ☐ Soon ☐ Urgent ☐ For urgent referrals please contact a member of the care team directly - see contact details below
Diagnosis:	
Brief Summary of Child's Current Condition and Description of medical needs:	Stable ☐ Unstable ☐ Deteriorating ☐ End of Life ☐
Prognosis:	
Reason for Referral - How do you think LauraLynn may best support this child and family?	
Does this Child/Young Person have a Life-Limiting Condition?	YES ☐ NO ☐ Comments:
Is this Child/Young Person expected to live beyond 18 years?	YES ☐ NO ☐ Comments:
Have you completed the Helen& Douglas House Guide?	YES ☐ NO ☐ Comments:
Has this been discussed with the child's parents?	YES ☐ NO ☐ Comments:
Has this been discussed with the child?	YES ☐ NO ☐ Comments:
Does this child have an Advanced Care Plan?	YES ☐ NO ☐ Comments:

PLEASE PROVIDE COPIES OF ANY ADDITIONAL INFORMATION/REPORTS THAT YOU FEEL MAY BE RELEVANT TO THIS REFERRAL

Paediatrician's Signature: Date:

Please complete and return to:

Referrals Panel
Lauralynn, Ireland's Children's Hospice
Leopardstown Road
Foxrock,
Dublin 18
D18 X063

T: 01-268 6680 / 01-289 3151
F: 01-289 9972
E: referrals@lauralynn.ie

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Siblings/Significant Family Members

Name	Male/Female	Date of Birth	Additional (Health) Needs
1.			
2.			
3.			
4.			
5.			

Professional Involvement – Health Care Professionals

e.g. Outreach Nurse, Public Health Nurse, Social Worker, Physiotherapist,

Name	Title/Role	Telephone Number/Email Address
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Additional Services involved in the care of child and family

e.g. School, Disability Service, Nursing Agency, Specialist Palliative Care Team, Neurology Team, Respiratory Team

Organisation/Service	Name of Lead Contact Person	Title / Role	Telephone Number/Email Address
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			