**Referral Form for HSE Adult Day Services – CHO 1**

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| --- |
| **I confirm that the referral process and purpose has been explained to me. I consent that information may be shared as appropriate by relevant health and social care professionals and transport providers in the processing of this referral.**  Applicant / Specified Person Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 1: Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Details** | | | |
| First name(s) |  | Surname |  |
| Address |  | | |
| County |  | Eircode (**mandatory**) |  |
| Contact no. (Landline) |  | Mobile |  |
| Email Address |  | | |

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| --- | --- | --- |
| **Next of Kin Details / person to contact in the event of an emergency** | | |
|  | **Contact 1** | **Contact 2** |
| Name |  |  |
| Relationship to person |  |  |
| Address |  |  |
| Contact no |  |  |
|  | | |

**Section 2: Service Requirements**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Day Service Required** | | | | | | |
|  |  | **HSE Day Centre wishing to attend** | | | | **Complete Sections** |
| Older Persons Day Hospital | ☐ |  | | | | 1 to 5 |
| Older Persons Social Centre | ☐ |  | | | | 1 to 5 |
| Mental Health Day Service | ☐ |  | | | | 1 to 4 |
| Disability Day Service | ☐ |  | | | | **1 to 4** |
|  | | | **Yes** | **No** |  | |
| Does this person have access to their own transport? | | | ☐ | ☐ | If **NO**, please complete Section 3 Transport Requirements | |
| Are there any other additional requirements needed to access transport | | | ☐ | ☐ |  | |

**Section 3: Transport Requirements (For completion only when a client does NOT have access to their own transport)**

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| --- | --- | --- | --- | --- | --- |
| **Transport Requirements** | | | | | |
| Requested Transport Start Date | / / / | | | | |
| Days Transport required | **M** | **T** | **W** | **T** | **F** |
| Name of person referring passenger: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact no. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Please advise of other requirements needed in order to travel independently  ☐ Assistance due to mobility issues  ☐ require assistance to get on/off bus  ☐ walking stick  ☐ frame  frame to travel with passenger Yes ☐ No ☐  ☐ wheelchair user *(see section below on wheelchairs)*  ☐ other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Consideration to pick-up time due to Home Help support  ☐ Specific Medical Needs *(see section 4.1 for further information)*  ☐ Cognitive Impairment *((see section 4.1 for further information)*  ☐ Person **not** to be dropped off at home by themselves if Carer is not present.  Please advise of who to contact in this instance  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is client deemed suitable for integrated transport Yes ☐ No ☐  Sit up independently Yes ☐ No ☐  Harness required Yes ☐ No ☐  Ability to follow instruction i.e. in event of an incident/accident? Yes ☐ No ☐  Travel Escort (If yes, what type) ☐ One to one **OR** Escort on Bus ☐  Has been introduced to the centre Yes ☐ No ☐  **Consent to share next of kin contact details to travel escort and driver: Yes ☐ No ☐**  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

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| --- | --- | --- |
| **Mobility** |  |  |
| **☐ Walking Stick** | | **☐ Frame** |
| **☐ Wheelchair User**  If yes, please advise of the following   1. ☐ HSE provided ☐ Bought privately 2. ☐ Headrest ☐ Foot Paddles ☐ Crash Tested ☐ Don’t know   Name and number of relevant OT  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| --- | --- | --- | --- |
| **For SITC use only** | | | |
| **Operator:** | | | |
| **Route:** | | | |
|  | **Yes** | **No** | **Comments** |
|  |  |  |  |
| Capacity on bus | **☐** | **☐** |  |
| Days seats requested available | **☐** | **☐** |  |
| Alternative dates offered | **☐** | **☐** |  |
| Additional distance required | **☐** | **☐** |  |
| Additional time required | **☐** | **☐** |  |
| **Home Access** |  |  |  |
| Access road suitable for bus | **☐** | **☐** |  |
| Space to turn at house | **☐** | **☐** |  |
| Pull up close to door | **☐** | **☐** |  |
| **Passenger** |  |  |  |
| Passenger confirmed suitable for travel | **☐** | **☐** |  |
| Proposed Start date | **☐** | **☐** |  |
| Operator informed | **☐** | **☐** |  |
| Travel Escort informed | **☐** | **☐** |  |
| Seating Plan updated | **☐** | **☐** |  |
| Date Transport Approved | **☐** | **☐** |  |

**Section 3: Transport Requirements**

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| **If additional cost is required:** |  | **Date** |
| Additional cost: | € |  |
| Cost submitted to: |  |  |
| Approval granted by: |  |  |

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| **Section 4 Referrer Details** | |  | |  | | | |  |
| Referrer Name |  | | | | | | | |
| Title |  | | | | | | | |
| Referral Body / Organisation |  | | | | | | | |
| Address |  | | | | | | | |
| Telephone No. |  | | | | Email |  | | |
| Information and reports obtained by the HSE are stored on computer (database), for the purposes of providing supports to access and provide HSE Adult Day Services. The information will be stored and disclosed in accordance with the Data Protection Act 1988 and 2003. | | | | | | | | |
| Please ensure that all relevant parts of this form are completed. The Referrer must sign the completed referral form.  **Signed by Referrer** | | | | | | | | |
|  | | |  | | | |  | |
| **Print Name (above)** | | | **Signature** | | | | **Date** | |

***Data Protection Notice***

*The HSE and SITC T/A Local Link Donegal Sligo Leitrim confirm that they are fully compliant with the General Data Protection Regulation (GDPR) and undertakes to maintain personal data in secure conditions with appropriate technical and organisational measures to protect it from unauthorised access or use. The data held about you will be disclosed to relevant staff and other relevant parties on a need-to-know basis within the HSE and SITC T/A Local Link Donegal Sligo Leitrim. All staff are made aware of the procedures they must follow to ensure that your data is appropriately protected*.

***NOTE: Only sections 1,2,3 and 4 are required for Transport***

**The following information is for HSE use only and will only be shared with Transport Operator if required**

**Section 4:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Section 4.1 Medical History** |  |  |  |
| **Relevant Medical History** Yes ☐ No ☐ If yes, please give details (e.g. seizures, diabetic, peg tube, tracheotomy, etc)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Cognitive Impairment Yes** ☐ No ☐ If yes, please advise of the following:   * ☐ Ability to understand instruction * ☐ Wandering Risk * ☐ Able to lock up own home | | | |
| **Section 4.2 Details of Disability** | **Tick All Appropriate** | **Notes** | |
| Autistic Spectrum Disorder | ☐ |  | |
| Head Injury | ☐ |  | |
| Hearing | ☐ |  | |
| Visual | ☐ |  | |
| Mental Health | ☐ |  | |
| Physical | ☐ |  | |
| Intellectual Disability | ☐ |  | |
| Mild | ☐ |  | |
| Moderate | ☐ |  | |
| Severe / Profound | ☐ |  | |
| Not Specified | ☐ |  | |
| Specific Learning Difficulty | ☐ |  | |
| Other – Please Specify | ☐ |  | |

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| **Section 5 Living Conditions** |  | | * **Not required by transport** | |  | |
| **Lives Alone** | **☐** | | **Lives with another elderly person** | | **☐** | |
| **Lives with family member(s)** | **☐** | | **Home Help**  What time(s) does Home Help call \_\_\_\_\_\_\_\_\_\_\_\_\_ | | **☐** | |
| **Other** |  |
| **Home Condition** (please tick all relevant) | | | | | |
| ☐ Single Story ☐ Water  ☐ Two Story ☐ Electricity  ☐ Bath ☐ Heating  ☐ Shower ☐ Isolated | | | | Needs assistance with continence Yes ☐ No ☐  If yes what incontinence wear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is medication required during the day Yes ☐ No ☐  Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dietary Requirements Yes ☐ No ☐  Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| --- | --- | --- | --- |
| **Section 5.2 Personal Details Not Required by Transport** | | | |
| Date of Birth |  | Gender (M/F/O) |  |
| GP |  | | |
| PPS No. |  | Medical Card No. |  |