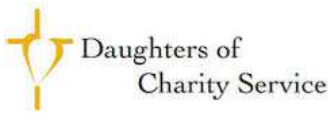

CHO Dublin North City and County
School Aged Team (SAT) Referral/Screening Form
5 years - 13 years 11 months

Office use only:
- □ Date logged on database: ________________
- □ Date received: ________________
- □ Acknowledgement: ________________

CHO Dublin North City and County
School Aged Team (SAT) Referral/Screening Form
5 years - 13 years 11 months

REFERRER DETAILS *Form Completed by:*

Name	
Title	
Signature	
Date Completed	

PERSONAL DETAILS

Child's Name:	**Date of Birth:**
Gender: **Male** □ **Female** □	**Child's Age:** **Years** **Months**
Address of Child:	
Mother's Name **Telephone:** Mobile Landline **Address:** *(if different from child's)* **Email Address:**	**Father's Name** **Telephone:** Mobile Landline **Address:** *(if different from child's)* **Email Address:**
Name of Legal Guardian(s): **Who does the child live with?** *(If living with Foster Parents, please also include their names/contact details).*	

Reason for referral

What are your main concerns regarding your child's development?

Medical Information/Present Health

Has a diagnosis been made or a condition identified?	Yes □ No □ Not Sure □

If yes, what is the diagnosis/condition?	
If yes, **when** was the diagnosis made? Who made it?	
Does your child have difficulties with vision? *(If yes, please describe)*	Yes □ No □
Does your child have difficulties with hearing? *(If yes, please describe)*	Yes □ No □
Other relevant medical history and current medical needs e.g. epilepsy, heart condition, hospital admissions? Please give details including hospital and nursing needs, breathing or feeding supports	
Is your child on any medications *(please list)*	Yes □ No □

Has your child ever attended any of the services below? *Give details:*			
Profession/Service	**Name & Location**	**Telephone**	**Report attached**
GP			
Public Health Nurse			
Paediatrician			
Speech and Language Therapist			
Occupational Therapist			
Physiotherapist			
Psychologist			
Social Worker			
Area Medical Officer			
Audiology			
Child Psychiatry			
Ophthalmology			
National Educational Psychological Services (NEPS)			
Other			

Is your child currently waitlisted for any services Yes □ No □ *(Give details – this could include family or parent interventions)* Has your child been discharged from any service in the last 12 months Yes □ No □ *(Please specify):*
Have you or your child attended any programmes/courses/training? Yes □ No □ *(Please specify):*
Are you or your child waitlisted for any programmes/courses/training? Yes □ No □ *(Please specify):*
Has your child been referred for Assessment of Need (AON)? Yes □ No □ *If your child has received AON, please attach reports.*

BACKGROUND INFORMATION: School

What type of education provision does your child receive?		
School □ School Name & Address: Class attended: Mainstream class □ Special Class □ ASD unit □ Contact Number: School Principal: Email:	Home Tuition □ Tutor Name: Tutor Contact Number:	Home School □
What supports does your child receive in school? Resource teaching □ Learning Support □ SNA □ Assistive Equipment □		

BACKGROUND INFORMATION: Family

Please indicate if there is any family stresses you feel is relevant to the referral? (*housing, financial, bereavement, illness, family break-up*)

Name(s) and age(s) of siblings:

Is a sibling involved in other services? Yes □ No □ *(If yes please specify)*

What are the languages spoken in the home?	
Do you require an interpreter?	Yes □ No □

YOUR CHILD'S DEVELOPMENT

Please complete all sections. Some questions may not be relevant for your child

MOVEMENT

Has your child achieved the following? *(please tick√)*	Yes	Developing	No	Not Sure
Walking independently				
Running				
Jumping				
Climbing				
Hopping				
Skipping				
Throwing and catching a ball standing still				
Throwing and catching a ball on the move				
Kicking a ball				
Pedalling a bike				
Do any of the following describe your child's movement? *(please tick√)*	**Yes**		**No**	**Not Sure**
Trips or Falls a lot				
Tires easily				
Bumps into other things a lot				
Always on the go, beyond what you would expect for their age				
Avoid movement games/activities e.g. swing, chase				

Does your child move to play / take part in active games or sports? Yes □ No □
(Please list)

Have you any concerns about your child's posture (*Lying, Sitting or Standing*) Yes □ No □
(Please provide details)

Does your child over or under react to pain or minor injury? Yes □ No □
(Please provide details)

Does your child have a mobility aid? Yes □ No □
(Please provide details)

How does your child's physical skills impact on his/her daily life?

FINE MOTOR / HAND SKILLS

Which of the following can your child do? *(please tick√)*	Yes	Developing	No	Not sure
Pick up small objects such as raisins or beads.				
Play with constructional games e.g. building blocks/Lego				
Use a pencil/pen				
Is your child's handwriting appropriate to age/class?				
Does your child have a hand preference? *If yes, indicate right or left.*				
Does your child use 2 hands together well?				
Cut with scissors				
Does your child have difficulty starting activities or appear tired or not interested?				

How does your child's fine motor skills impact on his/her daily life?

DAILY LIVING SKILLS

Do you have any concerns about your child's eating and drinking? Yes □ No □

(If yes, please describe)

Is your child a fussy eater Yes □ No □
(If yes, please describe)

Does your child have strong preferences for food textures/types? Yes □ No □
(If yes, please specify)

Which of the following can your child do? *(please tick√)*	**Independent**	**With Help**	**Full help required**
Use a cup			
Use a spoon			
Use a fork			
Use a knife			
Undress			
Dress			
Tie shoelaces			
Zips/Buttons/Fasteners			
Wash			
Brush teeth			
Is your child toilet trained by day?			
Is your child toilet trained by night?			

Does your child have strong preferences for clothes textures? Yes □ No □
(If yes please specify)

Do you have any concerns about your child's sleep? Yes □ No □
(If yes describe)

Does your child tolerate hair cutting, hair washing, nail cutting? Yes □ No □

Does your child under or over react to any sense, vision, smell, taste, sound? Yes □ No □
(If yes specify)

Do you have any concerns about your child's safety awareness in home/community e.g. hot surfaces/open traffic? Yes □ No □
(*If yes, please describe)*

Do you have any concerns about your child's self-care skills e.g. organising belongings, managing routines?
Yes □ No □
(*If yes, please describe)*

Does your child participate in age appropriate household chores? Yes □ No □
(*If yes, please describe)*

Any further comments on how your child is managing his/her independence compared to other children of similar age? Yes □ No □

(*If yes, please describe)*

COMMUNICATION

How does your child express himself/herself
(e.g. words, gestures, actions, communication device, lámh, PECS, sign-language.)

Does your child have any unusual characteristics of communication
(e.g., repeat words or phrases, unusual intonation, accent)

Do you have any concerns about your child's ability to communicate? Yes □ No □
(*If Yes, please describe)*

What age did your child start using words and sentences?

If using sentences give an example of a typical sentence he/she would use:

Do any of the following describe your child's speech, language and communication ability? *(please tick*√*)*	**Yes**	**No**	**Not sure**
My child has difficulty telling a story e.g. telling me about school day			
My child gets confused when I give him/her long instructions			
My child has difficulty expressing himself/herself (e.g. the amount of words my child can say)			
My child gets frustrated because he/she has difficulty expressing himself/herself			
My child has difficulty with speech and sounds (e.g. my child's speech is difficult to understand compared to other children)			

BEHAVIOUR AND EMOTIONS

Do you have any concerns about your child's behaviour at home? (e.g. tantrums, aggression, hyperactivity, self-injurious, obsessions/compulsions) Yes □ No □
(*If yes, please describe)*

Do you have any concerns about your child's behaviour at school? Yes □ No □
(*If yes, please describe)*

Do you have any concerns about your child's emotional development? Yes □ No □
(If yes please describe e.g. withdrawn, shy, anxious, low self-esteem)

What is the impact of these behaviours on the child? *Please circle (0 being the lowest and 10 the highest)*
0 1 2 3 4 5 6 7 8 9 10

(Please describe):
What is the impact of these behaviours on the family? *Please circle (0 being the lowest and 10 the highest)* 0 1 2 3 4 5 6 7 8 9 10 *(Please describe):*
Does your child have any unusual habits or seek out anything unusual? Yes □ No □ (*If yes, please describe)*
Does your child follow daily routines? Yes □ No □
Does your child become upset if the routine is changed? Yes □ No □

Activities/Interests/Hobbies

What are your child's favourite activities/hobbies?	
What toys does your child like to play with?	
Does your child play in an unusual way with toys or objects?	
What type of play does your child enjoy best	
Who does your child mostly play with? What age are they?	
How does your child like to play?	***(please √ tick as many as appropriate)***
Alone	
Next to other children but not with them	
With other children	
My child shows an interest in other children	
My child will turn take when playing with other children	
My child will share toys with other children	
What activities does your child like doing?	
What play or social activities does your child join in the community?	
Any further comments about your child's play/friendship/peer activities	

Learning and school

Do you have any concerns about your child's ability to learn new skills? *If yes, please describe (attach relevant reports)*
Has anyone ever expressed concerns about your child's ability to learn? (eg school teacher, Public Health Nurse, GP, Psychologist, family member etc? *If yes, please describe (attach relevant reports)*
Describe how your child manages homework.

Do you have any concerns about your child's ability to concentrate? Yes ◻ No ◻ *If yes, please describe*
Any further comments about your child's learning/previous assessments.

ADDITIONAL FAMILY INFORMATION YOU FEEL IS RELEVANT TO YOUR CHILD'S REFERRAL

PLEASE ATTACH ALL RELEVANT REPORTS

CONSENT

It is required by law that at least one of the child's legal guardians consents to the referral and signs this form.

I/We give permission for my/our child to be referred to the SAT team.

I/We give permission for information about our child to be held by the SAT team in accordance with our obligations under the Data Protection Acts 1988 and 2003. (If you require more information about this please contact the named person below)

I/We give consent to the Coordinator of the SAT team to contact and obtain relevant information from relevant professionals.

Parent/Guardian's Signature: ____ **Date:** ______________

Parent/Guardian's Signature: ____ **Date:** ______________

A legal guardian of a child is:

- Where the child's parents are not married, the child's mother only.
- Where the child's parents are not married, the mother of the child & the child's father or any other named person when appointed guardian further to a successful court application for guardianship.
- Where both parents are married, the child's mother and father are legal guardians.
- Following a separation or divorce, both parents remain the child's legal guardians, even if the child is not living with them unless otherwise directed by the courts.
- Where the child's parents are not married and the child's mother and father have entered into an agreement which has the effect of making the father the guardian of the child.