***Please note: incomplete referrals WILL NOT be processed.   
Please ensure consent from client/ family for referral prior to completing same.*** Date of Referral:

***Prior to completing/sending this referral, please refer to pre-referral guidelines and pathways for CRC Specialist Clinics***

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| **CLIENT INFORMATION** |
| **Client’s name**: **Date of Birth**: (DD/ MM/YYYY):  **Gender**: Male ⬜ Female ⬜ Other ⬜  **Address**:  **Postcode**: **Mobile Phone**:  **Other Phone**:  **Client lives with**: Parents ⬜ Mother ⬜ Father ⬜ Foster Family ⬜ Legal Guardian ⬜ Alone/Independently ⬜  **Name(s) of caregivers**:  **Language/s spoken at home**: **Interpreter required?** Yes ⬜ No ⬜ |
| **MEDICAL INFORMATION** |
| **Client’s Current and/or Working Diagnosis**:    **Current Function: Ambulant** ⬜ ***Non-Ambulant*** ⬜  Independent ⬜ Stick/crutches ⬜ Frame/KPW ⬜ *Manual Chair* ⬜ *Powerchair* ⬜  *Please elaborate on devices used:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List of orthoses/splints currently used/previously used by client: **Upper Limb** ⬜  **Lower Limb** ⬜  *(bilateral/unilateral; Type; Night/Day splint etc)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Current medication/s and doses**: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Previous medical interventions:** Botulinum Toxin ⬜ Surgery ⬜ Other ⬜  *Please elaborate (were these effective?)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Does the client present with contractures (fixed tightness)?**: Yes ⬜ No ⬜ *Please elaborate on joints contracted*:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PLEASE ATTACH A COPY OF ALL PERTINENT CONSULTS, REPORTS AND MEDICAL INVESTIGATIONS  **When referring to these services, the following additional information (if available) is required**:  Recent Therapy Reports ⬜ Medical Report ⬜ Has the client had recent X-rays/Imaging? Yes ⬜ No ⬜ |
| **REASON FOR REFERRAL** |
| **Specific Referral Question/s**: *(Please Include impact of spasticity on client’s day to day life)*    **Area/s hoping to address with referral**: Global tone management options ⬜ *and/or*  Botulinum Toxin suitability for: upper limb/s ⬜ lower limb/s ⬜ upper and lower limbs ⬜ (R ⬜ L ⬜ bilateral ⬜)  **Goal area/s to address**: Function ⬜ Aesthetic ⬜ Care and Comfort ⬜ Pain management ⬜  **Any other relevant information:** *(Communication methods, Behavioural profile, Cognitive profile..etc):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CLIENT/CARER’S PRIMARY CONCERNS/GOALS:ASON FOR REFERRAL** |
| **Area/s**: ⬜ Pain *specify:*  ⬜ Deterioration in gait/mobility *specify:*  ⬜ Deterioration in function *specify:*  ⬜ Deterioration in care needs *specify:*  **Any other relevant information:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **REFERRER’S AND TEAM INFORMATION: *THIS INFORMATION IS ESSENTIAL AND REFERRAL CANNOT BE PROCESSED WITHOUT SAME***  **Tone management referrals require consultant to consultant referral(medical letter can accompany this form)** |
| **Referring Physician/Clinician:** (*Print Name*):  **Email address:**  **Office telephone:**  **Mobile Phone:**  **Referrer’s Signature:**  **Postal Address:**  **Name of Family G.P.:**  **Client’s Paediatrician/Consultant Physician:**  **Client’s primary therapy team details: Service Name:**  **Service Address:**  **Primary Physiotherapist:** **Tel:** **Email:**  **Primary Occupational Therapist:** **Tel:** **Email:** |

***Please return COMPLETE referral form to:***

***Postal:*** Tone Management Referrals, Central Remedial Clinic, Vernon Avenue, Clontarf, Dublin, D03 R973

***Email:*** [specialistreferrals@crc.ie](mailto:specialistreferrals@crc.ie)