



Primary Care

Additional Information Form to Accompany Children's Services Referral Form

Child aged from 3 years to 5 years 11 months

Who should use this form

This form should be completed by the child's parents, with the help of the referrer if necessary. It should be sent with the Children's Services Referral Form.

Date of Referral Referrer

Please also attach any health or other reports you have on your child.

Child's Surname Child's First Name

Date of Birth

Parents' names and contact details

Birth history

(Please attach any relevant reports)

Length of Pregnancy Weeks/days Place of Birth

Birth Weight

Was your child admitted to the neonatal unit? Yes No

Has your child ever been in hospital since they were born? Yes No

If Yes, for what reason?

Please give details of medications, hospital and nursing needs, breathing and feeding supports.

Your child's development

Please note some questions may not be relevant for your child.

1. Movement and Gross Motor Skills

Has your child achieved the following?

Walking independently Yes At what age Not yet

Running Yes At what age Not yet

Jumping Yes At what age Not yet

Climbing up and down stairs Yes At what age Not yet

Throwing a ball Yes At what age Not yet

Catching a ball Yes At what age Not yet

Kicking a ball Yes At what age Not yet

Please tick if any of the following describe your child's movements.

Trips more than other children their age <input type="checkbox"/>	Falls more than other children their age <input type="checkbox"/>
Bumps into other things more than other children their age <input type="checkbox"/>	Tends to walk on tiptoes <input type="checkbox"/>
Clumsier than other children their age <input type="checkbox"/>	My child is losing skills they did have <input type="checkbox"/>
My child's posture looks different from other children <input type="checkbox"/>	

If you have ticked any of these, give details.

Is your child keeping up with other children of their age in physical development and activity? Yes No

If No, give examples.

Describe any other concerns you have about your child's movement and gross motor skills.

2. Fine Motor Skills and Hand Movement

Which of the following can your child do if they have had a chance to try it?

Pick up small objects such as raisins or beads	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Play with construction toys such as building blocks or Lego	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Use a pencil or crayon to scribble or draw	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Use a child's scissors to cut paper	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Open their lunchbox	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Describe any concerns you have about your child's fine motor and hand movements.

3. Communication, Speech and Language

Please explain how your child communicates most of their messages now? (e.g. crying, pulling, pointing, sounds, gestures, uses signs, uses pictures, words, sentences or a combination of these?)

Has your child achieved the following?

First words, such as 'cat' 'more'?

Yes

At what age

Not yet

Skill achieved but since lost

Putting two words together?

Yes

At what age

Not yet

Skill achieved but since lost

How many words can your child put together now in a sentence?

Give an example of the kind of things your child says now.

Do any of the following describe your child's speech, language, and communication abilities?

My child has difficulty understanding what I say

Yes

No

If yes, please give examples.

My child has difficulty telling a story, such as telling me about something that happened during their day

Yes

No

My child finds it hard to pronounce/say certain sounds, for example says "tup" for "cup"

Yes

No

Please give details of any concerns you have about your child's speech, language, communication and voice.

4. Social Interaction, Relationships, Play and Leisure

When playing does your child allow you or other adults to join in?

Always Sometimes Never

When playing does your child allow other children to join in?

Always Sometimes Never

Describe how your child plays with others.

Does your child show an interest in other children?

Yes No

Does your child take turns with other children?

Yes No

Does your child share toys with other children?

Yes No

What toys does your child like to play with and how do they play with them?

Does your child engage in imaginative play e.g. pretend and make believe games?

What activities do your child like to do?

Please give any further comments about your child's play, friendships and activities.

5. Daily Living Skills

5A. Food and Drink

Do you have any concerns about your child's weight or growth?

Yes

No

If Yes, give details.

Please enclose any growth or weight charts available.

Do you have any concerns about how much your child eats and drinks, or the range of foods they eat?

Yes

No

If Yes, give details.

Describe your child's usual food, drinks and mealtime routine?

Can your child use a spoon to feed themselves?

Yes

No

Can your child drink from a cup by themselves?

Yes

No

If No, give details.

Do you have any concerns about **how** your child is eating, swallowing and drinking?

Yes

No

If Yes please describe.

Are mealtimes stressful?

Yes

No

If Yes please describe.

Is your child on any specialised feeds, drinks or food?

Yes

No

If Yes, give details.

5B. Urinary and Bowel Habits

Please describe what stage your child has reached with toilet training.

Are there any issues around toileting?

Yes

No

If Yes, describe.

5C. Personal Care, Dressing and Independence

Does your child dress themselves?

Yes

No

With some help

Does your child undress themselves?

Yes

No

With some help

Describe what your child can do for themselves.

Have you any concerns about your child's safety awareness in the home or out and about?

Yes

No

If Yes, describe.

5D. Sleep

Do you have any concerns about your child's sleep routine?

Yes

No

If Yes, describe.

Have you any concerns about your child's level of energy?

Yes

No

If Yes, describe.

6. Behaviour and Emotions

Have you any concerns about your child's emotional wellbeing and behaviour?

At home

At crèche, pre-school or school

Out and about

Please describe any concerns.

Do the following statements describe your child? (Please tick the appropriate boxes)

Frequent prolonged tantrums

Aggressive

Irritable

Excessive Crying

Clingy

Upset for seemingly minor things

Withdrawn/too quiet

Doesn't like change

Frustrated

Worries a lot

If Yes to any of the above, how often does this occur?

Daily

Weekly

Monthly

Less often

What impact does this have on your child and on your family and what helps to prevent problems?

7. Learning

Do you have any concerns about your child's ability to learn new skills?

Yes

No

If Yes, describe.

Has anyone else expressed any concern about your child's ability to learn such as a teacher, psychologist, family member?

Yes

No

If Yes, give details of the concern and who expressed it.

Do you have any concerns about your child's ability to concentrate?

Yes

No

Is your child having any difficulties keeping up with learning or school work?

Yes

No

If Yes give details.

8. Vision and Hearing

Does your child have vision problems which cannot be corrected with glasses?

Yes

No

If Yes, give details.

Does your child attend a specialist service for their vision or hearing?

Yes

No

If Yes, give details.

9. Sensory Processing

If you have concerns about your child's sensitivity to any of the following, either avoiding them, getting annoyed with them or seeking them out, please tick:

Noise <input type="checkbox"/>	Touch <input type="checkbox"/>	Textures (such as fabrics) <input type="checkbox"/>	Movements <input type="checkbox"/>
Smells <input type="checkbox"/>	Food <input type="checkbox"/>	Lights <input type="checkbox"/>	

If you have ticked any of the above, describe how this impacts on everyday life for your child and for you.

10. Is there anything else you would like to tell us about your child?

Tell us what your child enjoys and is good at as well as the things they find difficult.

What is your main concern and priority for your child?

Safety and Risk

Are there any issues which are a significant risk to the health and wellbeing of your child or others, such as physical injury to self or others, refusal to eat?

Please give details of who completed this form

Form completed by

Relationship to child

Contact details

Date

N.B. Please attach copies of any health, school or pre-school reports that you have.

Any other information you want to give us