**MDT SERVICE – TUSLA REFERRAL FORM 2025**

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| **1.BASIC INFORMATION**  |
| ***Name of Referrer*** |  | ***Date of Referral*** |  |
| ***Job Title*** |  | ***Tusla Area/Region*** |  |
| ***Social Worker /Solicitor*** |  | ***Referrer’s Email***  |  |
| ***Referrer’s Mobile No.*** |  | ***Referrer’s Office No.***  |  |
| ***Referrer’s Address***  |  | ***Name of Principal Social Worker*** |  |
| ***Email of Principal Social Worker*** |  |
|  |
| **Name of Child(ren) referred** |  | **M / F** | **DOB** |  |
| **Name of Adult(s) referred** |  | **M / F** | **DOB** |  |
|  |
| **Nationality** |  | ***Are translation services required? If so please specify*** |  |
| **Address/Location** | ***Parent’s Address 1.***  |  |
| ***Parent’s Address 2. (where relevant)*** |  |
| ***Child (ren)’s Primary Residence*** |  |
| **Foster Placement Details****(*if relevant)*** | ***Name(s) / Initials of Foster Carer(s)*** |  |
| ***Location of Foster Carer(s)*** |  |
|  |
| **Legal Status*****Indicate where relevant*** | * Full Care Order (s.18) [ ]
* Interim Care Order [ ]
* Voluntary Care [ ]
* Emergency Care Order [ ]
* Other (*e.g. S47 Child Care Act, 1991*) [ ]
* Family Law; S20 [ ]
 |
| **Is the child listed on the Child Protection Notification System?** | Yes [ ] No [ ]  | **Category** | * Physical Abuse [ ]
* Sexual Abuse [ ]
* Emotional Abuse [ ]
* Neglect [ ]
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| Does the **subject CHILD** have any identified special needs or diagnoses? | Yes [ ] No [ ]  | ***Details*** | * Mental Health [ ]
* Physical Health [ ]
* Educational/Learning Difficulties? [ ]
* Developmental Delays [ ]  Autism/ ADHD [ ]
* Any known risk of violent behaviour? [ ]
* General Emotional/Behavioural Needs [ ]
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| Does the **subject ADULT/PARENT** have any identified special needs or risk factors? | Yes [ ] No [ ]  | ***Details*** | * Mental Health [ ]
* Physical Health [ ]
* Addiction [ ]
* Learning Difficulties [ ]
* Autism/ ADHD [ ]
* Other – Please specify [ ]
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| **2. REASON(S) FOR REFERRAL** |
| What is the main reason for the referral? |  |
| What questions do you need this assessment to answer? *Please be as specific as possible to ensure the assessment plan matches the referral needs.*  |  |
| Is there any factor which could impact on the deliverable timeline for this assessment? e*.g. annual leave re: client / professionals, family illness, other assessment appointments, volume of existing file for review, funding, awaiting Court order/directions* |  |

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| **3. ASSESSMENT DETAILS *RE: CHILD CARE / CHILD PROTECTION SERVICES***  |
| ***Type of Assessment(s) required:*** | * Speech and Language Therapy Assessment [ ]
* Occupational Therapy Assessment [ ]
* Specialist OT Assessment (e.g. Sensory Integration [ ]
* Multidisciplinary Assessment of Need (Psychology + SLT + OT)[ ]
* Specialist Trauma Informed MDT Assessment[ ]
* Autism/ADHD diagnostic assessment [ ]
* Psychological Assessment (Adult [ ]
* Psychological Assessment (Child) [ ]
* Parenting Capacity Assessment [ ]
* Reunification Viability Assessment [ ]
* Specialist Attachment Assessment(s) [ ]
* Other/Bespoke consulting – please specify [ ]
 |
| ***Is this case currently the subject of legal proceedings?*** | Yes [ ]  No [ ]  | ***Please state the Application before the Court*** |  |
| ***Is there a Court Hearing date for which the assessment is required?*** |  | ***Location of Presiding Court*** |  |
| ***Do you need the assessor to attend Court as expert witness?*** |  |
| **Legal instructions/terms of court order guiding the assessment (if any)** |  |

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| **4. SCHOOL / EDUCATION INFORMATION** |
| **Does the Child attend school?** Yes [ ]  No [ ]  | **What class are they currently in?** |  |
|  | **Name of School** |  |
| ***Child is not attending school because*** |
|[ ]  Too young |[ ]  Child is excluded |
|[ ]  In alternative education/home schooled |[ ]  Refusing to attend |
|[ ]  Regular truancy |[ ]  Other |
| ***If the child has special needs – what supports are they currently receiving?*** |
|[ ]  Learning Resource Hours  |[ ]  Special Class/Special School placement  |
|[ ]  Support via NEPS |[ ]  Access to Special Needs Assistant  |

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| **5. SUMMARY OF SERVICES INVOLVED *Please tick any/all that apply in this case*** |
|[ ]  Social Work |[ ]  Community Psychology |
|[ ]  Family Support Worker |[ ]  CAMHS |
|[ ]  Child Care Worker |[ ]  AMHS |
|[ ]  Speech & Language Therapist |[ ]  Occupational Therapist |
|[ ]  Guardian Ad Litem |[ ]  Play/Art Therapist |
|[ ]  Counselling /Psychotherapy |[ ]  Paediatrician/Medical Consultant  |
|[ ]  Other - Please specify: |
| ***Have any professional services completed a report in this case in the last two years? If so, please specify.*** |

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| **6. ASSESSMENT HISTORY SHARING OF RELEVANT INFORMATION** |
| Should the quotation be accepted per terms of the funding agreement, please be advised we will require the following documents to be made available where possible.*Please indicate if reports are available or not applicable (Yes /No / N/A)* |
| **Social Work Reports** |  |
| **Risk Assessments** |  |
| **Psychology Reports** |  |
| **Educational Assessments / School Reports** |  |
| **Speech and Language Therapy /****Occupational Therapy Assessments/Interventions** |  |
| **Child in Care Plan (*where relevant*)** |  |
| **Health /Medical Reports** |  |
| **Copies of Court Orders (*where relevant)*** |  |

***Thank you for completing the referral form.***

***PLEASE EMAIL THIS COMPLETED FORM TO*** ***MDTreferrals@ffi.ie***

***We will revert with a quote and an assessment proposal as soon as possible.***

***Please phone 01- 417 1944 / O1-898 2333 if you need any further assistance.***