**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 | | | |
| 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 | | | |
| 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***](mailto: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.***