THE JACK & JILL CHILDREN'S FOUNDATION
REFERRAL FORM

Date received:

CHILD'S DETAILS

CHILD'S NAME: _____ DOB: _____/_____/_____ MALE _____ FEMALE _____

ADDRESS: _____Eircode : _____

MEDICAL HISTORY/DIAGNOSIS

(PLEASE INCLUDE A MEDICAL REPORT SUMMARY WITH THIS REFERRAL)

NEXT OF KIN

PARENT/GUARDIAN'S: _____ Email Address : _____

Phone : _____ Phone: _____

SIBLINGS: _____

NATIONALITY : _____ FIRST LANGUAGE SPOKEN: _____

HEALTH PROFESSIONAL

GENERAL PRACTITIONER:

CONSULTANT:

SOCIAL WORKER:

PUBLIC HEALTH NURSE:

HOSPITAL

OTHER SERVICES:

REFERRER DETAILS

NAME : _____ QUALIFICATION : _____ Address: _____

EMAIL : _____ CONTACT NO:_____ BLEEP:_____

PLEASE CONFIRM PARENTS/GUARDIANS HAVE GIVEN CONSENT TO THIS REFERRAL ☐

BENEFITS	APPLIED FOR	RECEIVED
MEDICAL CARD	☐	☐
DOMICILLARY CARE ALLOWANCE	☐	☐
LONG TERM ILLNESS CARD	☐	☐
CARERS BENEFIT	☐	☐
CARERS ALLOWANCE	☐	☐

PLEASE RETURN TO:

THE JACK & JILL CHIDLREN'S FOUNDATION, JOHNSTOWN MANOR, JOHNSTOWN, NAAS, CO. KILDARE

Email: familysupport@jackandjill.ie - Tel: 045 894538 - Fax: 045 894558