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: ____

Phone : __________________________________ Phone: ______________________________

SIBLINGS:

NATIONALITY : FIRST LANGUAGE SPOKEN:

GENERAL PRACTITIONER:

CONSULTANT:

SOCIAL WORKER:

PUBLIC HEALTH NURSE:

HOSPITAL

OTHER SERVICES:

REFERRER DETAILS

NAME : ______________________________ PHONE NO: _______________ BLEEP: _______________DATE: ______________

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	☐	☐
INCAPACITATED CHILD TAX CREDIT	☐	☐

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