BRÚ COLUMBANUS REFERRAL FORM

(To be completed by Clinical Nurse Manager, Staff Nurse or Social Worker)

Name(s) of Relatives: ____

Home Address: ____

____

____

Telephone number: __________________

Mobile number: __________________

Referral criteria: Please circle one of the following

1 **2** **3**

Patient's name: ___________________________

Hospital: ____

Ward: ____

Telephone Number of Ward/Department: _______________________

Number of Family Members requiring accommodation: ________

Name of Referrer and Position: _______________________________
PLEASE PRINT

Signature of Referrer: ______________________________

This form is to be faxed to Brú Columbanus by **11.30am** each day.

Fax number: 021 4345798

(Referral form continued)

<u>CRITERIA FOR ADMISSION TO BRÚ COLUMBANUS HOUSE</u>

1. **A seriously ill family member in the Intensive Care or Coronary Care Unit or a seriously ill family member where the family need to remain near them.**
2. **An in-patient whose immediate family lives a long distance from the hospital.**
3. **Estimated duration of stay.**

<u>Criteria 1 forms may be submitted up to 4pm in the case of emergency situations.</u>

The House Manager <u>must</u> be notified immediately of any change in the patient's situation/condition (e.g. – transfer, discharge, demise).

In the case of a family where their relative may have an infectious disease, the House Manager must be contacted directly before a referral can be made.