SOUTHWEST CIT

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CIT Referral Form- 1890 837 427
Referrals Faxed to 021- 4840093
ALL FIELDS **MUST** BE COMPLETED, otherwise patient will not be accepted

Patient Details

Surname: Forename: DOB:	Sex: ☐ Male ☐ Female Address/Discharge Address:	Next of Kin (NOK) Name: NOK Relationship & Contact No.
Pt Contact Number:	GMS/DPS/LTI/PPSN:	Living Alone? ☐ **Yes** ☐ **No**

Referring Source Details

Referring person & Ward/Hospital/PHN/GP	Date of referral	Time of referral

Ward & MRN (Medical Records Number)	Admission date to hospital	Consultant

Date to be seen by CIT	GP Name	GP Address & contact details

Discharge referral sent to: ☐ GP ☐ Physio ☐ PHN ☐ OT	Known allergies

Relevant Medical/Surgical/Psychiatric history, treatment received & current diagnosis (In addition, please provide discharge summary at time of discharge)

Copy of prescription supplied? ☐ **Yes** ☐ **No**	Has patient/NOK consented to CIT service & sharing of information? ☐ **Yes** ☐ **No**	Infection Control Status, MRSA, C-Diff, VRE, Other?
Mobility Status	Cognitive Status ☐ Orientated ☐ Confused	Reason for referral to CIT

Current vital signs
HR _________ BP ___________ SpO2 _________ LTOT Y / N
RR __________ Temp__________

Any additional Information/ Comments	

For CIT Office Use

Has patient been informed of the option to attend CIT clinic for treatment? ☐ **Yes** ☐ **No**	Are there any safety issues CIT staff needs to be aware of for home visits? ☐ **Yes** ☐ **No**	Any additional CIT information/comments:

YOU RECEIVE CONFIRMATION BACK FROM CIT THAT THEY CAN ACCEPT THE CARE OF YOUR PATIENT