PATIENT CONSENT TO REFERRAL: Yes ◯ No: ◯

NOTE ALL SECTIONS OF FORM TO BE COMPLETED

Emergency Department Referral to Community Healthcare Network

Patient's Name: _____
DOB:_____
MRN:_____
Home Address & Eircode: _____
_____
_____

Hospital : _____
Date of presentation to ED:_____
Date of discharge from ED : _____
Primary Consultant:_____
Patient Contact Number: _____
GMS/ Medical Card Number:_____

Referral Source

GP referral to ED ☐ South Doc referral to ED ☐
999 call to ED ☐ Self Presented ☐
Referred from other facility e.g. *hospital/LIU* ☐
_____

GP/ Carer Details

G.P.:_____
G.P. Address:_____
Main Carer:_____ **Relationship:**_____
Contact Number :_____

Hospital Presentation and Medical History

Reason for this hospital presentation/ diagnosis: _____
_____
_____

Past medical and surgical history: _____
_____
_____
_____

Previous ED presentation/Hospital Admission:_____
_____

Medications:_____
_____

Attached is a list of medications: Yes: ☐ No: ☐ **Allergies:**_____ **Anticoagulants:** Yes: ☐ No ☐

Examination/Results:

Pulse: _____bpm
BP Systolic/Diastolic:_____/_____mm/hg
Body Height: _____metres
Weight: _____kg
Body Mass Index: _____ kg/M^2
Lab Investigation:_____
_____
_____

Clinical Exam/Findings:_____
_____
_____
_____
_____
Radiology Investigation: _____
_____
_____

Summary of ED attendance

Diagnosis/ Treatment:

Follow Up Plan:

Patient Information/Social History:

Impaired Vision: Yes: ☐ No: ☐ **Impaired Hearing:** Yes: ☐ No: ☐ **Hearing Aids**: Yes: ☐ No: ☐
First Language:_____
Social Circumstance: Lives Alone: ☐ Not Alone: ☐ Frequent Visits: ☐ Details_____
Has this patient fallen in the last 6/12 months?: Yes: ☐ No: ☐ **Frequency/Location:**_____
Mobility: Independent: ☐ With Aid: ☐ With Wheelchair: ☐ Immobile: ☐
Aids Used/Assistance Required: _____
Transfers: Independent: ☐ With Mobility Aid: ☐ Sara Steady: ☐ Standing Hoist: ☐ Full Hoist: ☐
Cognitive Diagnosis: Yes: ☐ No: ☐ Details:_____ **Cognitive Concerns**: Yes: ☐ No: ☐
Mental Health History: Yes: ☐ No: ☐ Detail _____
Smoker: Yes ☐ No ☐ **Alcohol Consumption**: Yes ☐ No: ☐ Frequency/Units:_____

Emergency Department Referral to Community Healthcare Network

Additional Relevant Information: _____

_____

Current Services:

Support services used outside of primary care: None: ☐ Mental Health Services: ☐ ICPOP: ☐ ICPCD: ☐
Home Help: ☐ Meals on Wheels: ☐ Day-care Centre: ☐ Respite ☐
Details/Other: _____
Known to Primary Care Team: Yes: ☐ No: ☐ **Details:** Therapy: ☐ _____ PHN: ☐ Social Worker: ☐

Referral Reason:

Reason for referral/Anticipated outcome: _____

_____

Referral for: Nursing Service: ☐ Dietetic Service : ☐ Speech and Language Therapy Service : ☐
Physiotherapy Service: ☐ Occupational Therapy Service ☐

Nursing Referral:

Preventative Care: ☐ Palliative Care: ☐ Nursing Assessment: ☐ Hospital Discharge: ☐ Home Supports: ☐
Chronic Illness Management: ☐ Health Education/Promotion: ☐ Leg Ulcer : ☐ Continence Problem ☐
Other: ☐ _____
Wound Care: ☐ _____ Pressure Areas Intact: Y: ☐ N: ☐ Initial Wound Dressing Date: __/__/__
Frequency : _____ Dressing Type _____
Catheter Care: ☐ Type _____ Size: _____ Last changed __/__/__/
Long Term ☐ Short Term ☐ For trial without Catheter ☐ OPD arranged ☐ _____

Physiotherapy Referrals

Patients Baseline Mobility: _____ Patients Current Mobility : _____
Difficulty with transfers in and out of bed: ☐ Difficulty with transfers in and out of chair: ☐
Difficulty with walking inside: ☐ Difficulty with walking outside: ☐ Difficulty with walking on stairs or steps: ☐
Falls: ☐ Musculoskeletal referral: ☐ Details: _____

Occupational Therapy Referrals

Activity Daily Living: ☐ Detail : _____
Falls: ☐ Cognitive/perceptual: ☐ Moving, handling & transfers: ☐ Access to property & safety issues: ☐
Pressure care: ☐ Detail: _____ Wheelchair/seating: ☐
End of life/Palliative care: ☐ Palliative Care involved Yes ☐ No ☐ Other: ☐ _____

_____

Dietetic Referral: *Please answer the following questions one or more negative response would indicate dietitian referral*

1. Is your appetite**:** Good: ☐ Fair: ☐ Poor: ☐ **2**. Has your appetite reduced in recent months: Yes ☐ No ☐
3. Have you lost weight recently without trying: Yes ☐ No ☑ **4.** Are your clothes looser in the past 6/12 months: Yes ☐ No ☐ **5.** Have you been prescribed oral nutritional supplements: Yes ☐ No ☐

Speech and Language Therapy Referral

Does the patient have any of the following communication difficulties?
Receptive language difficulties: ☐ Expressive language difficulties: ☐ Dysarthria: ☐ Dyspraxia: ☐
Stammering: ☐ Other: ☐
Does the patient have any of the following eating, drinking or swallowing difficulties?
Dysphagia: ☐ Concerns re aspiration: ☐ Choking: ☐ Difficulty managing food: ☐ Difficulty managing fluids and food: ☐ Difficulty swallowing tablets: ☐ Other: ☐
Additional Information: _____

Referrer Name: _____ **Signature:** _____

Date: _____ **Contact Details:** _____

Please insert patient address into HSE Area Finder to identify correct CHN email address for referral

HSE Area Finder URL – https://hseareafinder.ie/