IMMUNISATION ADVICE Referral form

Name……………………………………………………………………………………

Date of Birth ………………………………….**MRN**……………………………….
Address:………………………………………………………………………………...
……………………………………………………………………………………………
……………………………………………………………………………………………..

Consultant……………………………………………………………….

Parent/Guardian…………………………………………………………
Contact Tel No ……………………………**Mobile**………………………

Advice / Information required.
………………………………………………………………………………………
………………………………………………………………………………………
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Parent <u>must</u> give consent for referral to take place.
***Please tick yes ……to indicate that you have discussed this referral with parent.**

<u>Referral completed by:</u>

Name ………………………………………………………………………..
Disipline ……………………………

Ward…………………… Ext no ……....... Date……………….

Please return form to Clinical Nurse Manager Immunisation, Seahorse Day Unit, Cork University Hospital, Wilton, Cork.

(Please leave patients notes in Day unit /on ward - do not send back to medical records as they are required for documentation of referral outcome.)

***Parents will be contacted by telephone (if patient is discharged) to discuss or provide information on immunisation.**
It is important that you have discussed this referral with a Parent prior to contact being made.

2016