

Please complete **ALL** questions as incomplete referral forms will be returned.

Receipt of this referral **does not** guarantee admission. **CNM confirmation required.**

Patient Details

Name: _____
 DOB: _____
 Address: _____

 Phone: _____
 Mobile: _____
 Vhi Policy No: _____

Admission Details

Hospital: _____
 Ward: _____
 Consultant: _____
 Date Admitted: _____
 EDD: _____
 Date Referred: _____
 Patient aware of referral: **Y** ☐ **N** ☐
 Consultant aware of referral: **Y** ☐ **N** ☐

NOK Details

Name: _____
 Address: _____
 Phone: _____
 Relationship: _____

GP Details

Name: _____
 Address: _____
 Phone: _____

Diagnosis on Hospital Admission						
Reason for Referral to Vhi Hospital@Home	IV therapy <input type="checkbox"/> VAC therapy <input type="checkbox"/> Anticoagulation <input type="checkbox"/> TPN <input type="checkbox"/> Post-operative care: Drain care <input type="checkbox"/> Stoma support <input type="checkbox"/> Pain <input type="checkbox"/> Vital signs <input type="checkbox"/> Blood Monitoring <input type="checkbox"/> Nurse Led Service: Complex Post-operative wound care <input type="checkbox"/> 5 -FU disconnection <input type="checkbox"/> Line Care <input type="checkbox"/> Suprapubic catheter <input type="checkbox"/> Urinary catheter <input type="checkbox"/>					
Allergies	NKDA <input type="checkbox"/>					
Treatment Plan: <i>Outline the full treatment to be provided: e.g. IV antibiotic regime, Wound goal of care etc.</i> For IV antibiotics:	Date Commenced:		Estimated Date of Completion:			
Infection Control Precautions						
Invasive Procedures During Hospital Admission <i>List all including siting of PICC Lines, surgical washouts etc.</i>	1. 2. 3.					
Most Recent Vital Signs	BP: /	Temp:	HR:	O2 Sats:	Weight:	KG
Patient to be discharged on Opiates	Yes <input type="checkbox"/> No <input type="checkbox"/>					
Alcohol Consumption	Units per week:					
Details of Person completing referral	Name:		Role:			
	Contact Details:					

Please ensure most recent blood results and Prescription is sent with this referral

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