Hospital@Home
Referral Form

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

Date of birth

Address

Phone

Mobile

Vhi policy no.

Admission details

Hospital

Ward

Consultant

Date Admitted

EDD

Date Referred

Patient aware of referral ◯ Yes ◯ No

Consultant aware of referral ◯ Yes ◯ No

Next of kin

Name

Address

Phone

Relationship

GP details

Name

Address

Phone

Diagnosis on Hospital Admission

Reason for referral to Vhi Hospital@Home

◯ IV therapy ◯ VAC therapy ◯ Anticoagulation ◯ TPN ◯ Early discharge support

Post-operative care ◯ Drain care ◯ Stoma support ◯ Pain ◯ Vital signs ◯ Blood monitoring

Nurse led service ◯ Post-operative wound care ◯ 5-FU disconnection ◯ Line care ◯ Suprapubic catheter ◯ Urinary catheter

Allergies

◯ NKDA

Treatment Plan

Outline the full treatment to be provided: e.g. IV antibiotic regime, wound goal of care etc.

For IV antibiotics | Date commenced | Estimated date of completion

Infection Control Precautions

Invasive Procedures During Hospital Admission

List all including siting of PICC Lines, surgical washouts etc.

1.
2.
3.

Most Recent Vital Signs

BP | Temp | HR | O2 sats | Weight KG

Patient to be discharged on Opiates

◯ Yes ◯ No

Alcohol Consumption

Units per week

Details of Person completing referral

Name | Role

Contact Details

Please ensure most recent blood results are sent with this referral

Vhi Hospital@Home, Waverley Business Park, Old Naas Road, Dublin 12, D12 H340

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NorthSide CNM **(086) 7728844**

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