Referral Form

Vhi Hospital@Home

Complete **ALL** questions. **Incomplete referrals will be returned**

Receipt of this fax **does not** guarantee acceptance to the service.

Do not send the patient home prior to CNM Assessment. **Patient will be sent back to hospital**

Patient Details

Name.....

DOB.....

Address.....
.....
.....

Phone.....

Mobile.....

VHI/Garda/ESB ***(please circle)***

Policy No.....

NOK.....

Address.....
.....

Phone.....

Relationship.....

GP.....

Address.....
.....
.....

Phone.....

Hospital.....

Ward.....

Consultant.....

Date Admitted.....

EDD.....

Date Referred.....

Patient Aware of referral ? YES ☐ NO ☐

Referring Consultant aware of referral? YES ☐ NO ☐

Diagnosis on Hospital Admission	
Reason for HomeCare referral (circle what appropriate)	IVs VAC AntiCoag TPN Drain Stoma
Allergies	**NKDA**
Treatment plan including antibiotic regime (if appropriate)	
Date commenced antibiotics **Estimated Date of completion**	**/ / 20** **/ / 20** **N/A**
Microbiology (bacteria isolated)	**N/A**
Invasive procedures carried out this admission (list all incl. non-surgical e.g. washout /PICC line	1. 2. 3. **N/A**

Most recent Vital Signs:

BP		Temp		HR		RR		Sats on RA		Weight	KG

Will the patient go home on opiates?	Yes	No
Does the patient drink alcohol	Yes	No
Units per week		N/A

N.B Attach most recent bloods

signed: _____

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