Community Reablement Unit Referral Form

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Our Lady's Hospice & Care Services

Gerontology Community Reablement Unit Harold's Cross

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ONLY FULLY COMPLETED REFERRAL FORMS MAY BE CONSIDERED

Patient's Name:	
Address:	
Telephone Number:	Date of Birth:

Medical Card Number:	Health Care Cover:

Name of next of Kin:	Relationship:
Address:	
Telephone Number:	

Name of GP:	Telephone Number:
Address:	

1. Have you discussed this referral with the patient? Yes No

2. Clinical Information:

Past Medical History:
Most Recent Hospital Admission Date:
Current Medications:

3 (a). Please state Primary goal for this admission:

_____

_____

3 (b). Please state any other rehab goals for this admission:

_____

_____

Please turn over ►

4. Please indicate category of urgency:

☐ **Category A –** Recent significant functional deterioration.
☐ **Category B –** At risk of losing independence.
☐ **Category C –** Unable to maintain a satisfactory quality of life.

5. Is discharge from hospital being facilitated by this referral? **Yes** **No**

6. Without Reablement would you be considering residential/nursing home placement? **Yes** **No**

7. Without Reablement would you be considering hospital admission? **Yes** **No**

8. Other Services Involved: (Very Important - Please complete this section fully)

A: Is the patient under the care of any other Hospital Services/ Specialists? **Yes** **No**

If Yes please state who:

Please enclose copies of any relevant correspondence for the above

B: Has the patient seen own GP recently and reason? **Yes** **No**

If Yes please state why:

C: Is the Patient known to Community Care/ DCU? **Yes** **No**

If Yes please state who:

D: Public Health Nurse Name:

Health Centre:

9. Does the patient live alone? **Yes** **No** (Please state social circumstances if known)

10. Please complete the following details if known:

Community Occupational Therapist Name: *Contact Number:*	Social Worker Name: *Contact Number:*
Community Physiotherapist Therapist Name: *Contact Number:*	Community Nurse: Name: *Contact Number:*

G.P. Signature: ……
(All referral forms must be signed by a GP)

Name and Title of Referrer: ……..
(Please complete if different from GP)

Telephone Number: …… Date: ……..

*** All names and phone numbers of additional community agencies involved in a referral should be provided for discharge information purposes***

Only Fully Completed Referral Forms will be considered. When Completed please return to Liaison Nurse/ Unit Secretary as soon as possible.