Community Reablement Unit
Referral Form

Tel: 01 4986232 Send to by post or email: cru@olh.ie

ONLY FULLY COMPLETED REFERRAL FORMS MAY BE CONSIDERED

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

Medical Card Number:	Does the patient have Health Care Cover: **Yes ☐ No ☐** Policy & No:_____ *** It is important this section is completed if the patient has 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 any other disciplines involved in Referral: (* Important please complete*)

…….

Telephone Number: ……. Date: ……..

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