

Cork University Dental School & Hospital In-Patient Referral Form



Please complete both sides and every section of this form **and** retain a copy for your records.

Referrals may be posted, emailed to UCCdental@healthmail.ie or delivered to -

Clinic Administration Officer, Room G44a, CUDSH (link corridor between CUH and CUDSH)

All referrals will undergo clinical triage. **Incomplete referrals will be returned.**

Referrals which do not comply with current CUDSH patient referral protocols will be returned.

IMPORTANT: CUDSH is an outpatient facility and is **not part of CUH**. It is the responsibility of the referring practitioner to ensure that patients are **medically suitable** for transfer.

Referrer Details

Referring Hospital/Clinic: _____ Ward: _____

Ward Contact Number: _____ Ward Porter Contact Details: _____

Referrer Name: (BLOCK LETTERS) _____

Position: _____

Signature: _____ Date: _____

Patient Details

First Name: _____ Family Name: _____

Date of Birth: _____ Parent/Guardian: _____

Email: _____

Mobile No: _____ Other Tel: _____

Patient Address:

Postcode: _____

Section A:

Reason for Referral / Clinical Request:

Clinical Information

Section B:

Medical History. Family History. Social History:
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Section C: (Medical notes/drug chart **must** accompany the patient)

Current Medications: (please include administration times for anti-coagulants)			
Does the patient have any communicable disease/infection?		Yes ☐ No ☐	If yes, please complete the table below.
Currently in Isolation?	Yes ☐		No ☐
Type of Isolation?	Contact ☐	Droplet ☐	Airborne ☐ Other: _____
History of C. difficile	Yes ☐		No ☐
CPE / CPE Contact	Yes ☐		No ☐
MRSA	Site: _____		Date Confirmed: _____
ESBL	Site: _____		Date Confirmed: _____
VRE	Date Confirmed: _____		
Wheelchair Transfer to CUDSH?	Yes ☐ No ☐		
Interpreter required?	Yes ☐ No ☐	Note – the referring hospital must arrange the interpreter.	
Can the patient mobilise independently for 30 metres without wheelchair?	Yes ☐ No ☐		
Has the patient/parent/guardian consented to this referral?	Yes ☐ No ☐		

Please check that all sections are complete to prevent return of this referral

For CUDSH Use Only:

Date Patient Registered: _____ **CDS No:** _____