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:

Please turn over

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Clinical Information

Section B:

Medical History. Family History. Social History:

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 ☐	**Details:**
Wheelchair Transfer to CUDSH?	Yes ☐ No ☐	**Details:**
Interpreter required?	Yes ☐ No ☐	**Note** – the referring hospital must arrange the interpreter.
Can the patient mobilise independently for 30 metres without wheelchair?	Yes ☐ No ☐	**Details:**
Has the patient/parent/guardian consented to this referral?	Yes ☐ No ☐	**Details:**

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

For CUDSH Use Only:

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