**(Please Complete in Block Capitals)**

**All correspondence should be sent to** **isolation.facility@hse.ie**

**For all queries contact 01 9210251 / 01 9210158 / 087 1800130**

|  |  |
| --- | --- |
| **Client Name:** |  |
| **Address**: |  |
|  **Gender:** [ ]  **Male** [ ]  **Female** | **DOB** (DD/MM/YYYY): / /  |
|  **Consent to receive Text messages: [ ]  Yes[ ]  No**  | **Tel/Mobile #:** |
|  **Parent/Guardian/ Next of Kin**  |  |  **GP Name**  |  |
|  **Relationship to client** |  | **Address** |  |
|  **Tel / Mobile #** |  | **Tel/ Mobile #** |  |
| ***Referral Source: Acute Hospital [ ]  GP [ ]  Assessment Hub [ ]  Public Health [ ]  Other [ ]*** ***If other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***Is patient a Healthcare Worker:* [ ] Yes [ ] No** |
| **Infectious Disease Status** **Please complete****all sections** | **COVID [ ]  Mpox [ ]  Chickenpox [ ]  Measles [ ]  Norovirus [ ]  Scabies [ ]  Other** [ ] If “Other” please state type of Infectious Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is the patient a confirmed case: [ ] Yes [ ] NoDate of onset of symptoms: */ /*  Type of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Or**: Date of contact with known / suspected case: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of test, if done (NOT date of result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last documented fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expected date of completion of isolation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vaccination Status (for Mpox, Chickenpox & Measles) : [ ] Yes [ ] No [ ] UnknownDate of vaccination:  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  |
| **Reason for Referral *i.e. reason they are unable to self-isolate at home, please be specific:*** |

|  |  |  |
| --- | --- | --- |
| **Background Information** | Smoker: [ ]  Yes[ ]  NoDrug Dependency: [ ]  Yes[ ]  NoAlcohol Dependency [ ]  Yes[ ]  NoPsychiatric Illness [ ]  Yes[ ]  NoSeizures/Epilepsy [ ]  Yes[ ]  No | **Interpreter required**: [ ]  Yes[ ]  No Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Past Medical History**  |  |
| **Medications****Please include Dose & Frequency** | **Does the resident have sufficient medication for their isolation period?** [ ]  Yes[ ]  No |
| **Allergies**  | **Dietary Requirements:** |
| **Mobility / Disability (Hearing / visual impairment)? Note that the potential resident must be self-caring****Please outline.**  |
| **Checklist for Referrer**:1. This Resident is suitable for isolation in a self-caring facility [ ]  Yes[ ]  No
2. The resident has agreed to isolated in the facility for necessary period of time [ ]  Yes[ ]  No
3. Has resident consented to this referral? [ ]  Yes[ ]  No
4. Has the resident consented to sharing of their information? [ ]  Yes[ ]  No
5. If discharging from an **Acute Hospital**, Discharge Summary attached [ ]  Yes[ ]  No

**Please confirm you will accept this patient back to your hospital should they become unwell**: **[ ] Yes [ ] No** **Signed: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date: */ /*** |
| **Referred By (Title & Name): PLEASE PRINT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Place of Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **For residents under 18 years of age:****Parent/Guardian/Next of Kin Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Important Information - Not to be returned with Referral Form**

**(To be given to Patients in advance of Admission)**

**Items to be brought by residents to Isolation Facility: -**

* Mobile telephone and a charger
* Enough personal clothing for the duration of your stay (up to 14 days)
* List of prescription medication
* Bring a supply of prescription medication for the duration of stay (up to 21 days)
* Reading glasses, if worn
* Laptop and charger if desired - Wi-Fi is available free of charge in the facility
* Apple iPad or android tablet or kindle if desired – Wi-Fi is available free of charge in the facility
* Reading materials such as books and magazines, study materials
* Notebook and pens (for personal use)
* Walking shoes, warm outdoor coat/raincoat, hat, scarf and gloves and an umbrella
* Personal toiletries and cosmetics
* Personal supply of face masks and alcohol gel, if you have them
* Own hairdryer if preferred
* Snacks/treats for own use. Dried products only. No take-away deliveries or perishable foods are allowed.

**Residents with children:**

Please note that in the event that you become unwell during your isolation period or require hospitalisation, your child(ren) will attend hospital ED with you and will be transferred to the care of the hospital social services during the period of your ED assessment or Treatment**.**

* Enough changes of clothing
* Nappies and or pull ups
* Baby wipes and baby toiletries
* Calpol and/or Neurofen
* Prescription medications
* Electric Steriliser and bottles – Microwave facility **not** available
* Toys, books, colouring books, colouring pencils & crayons and games
* Outdoor clothing

**Please do not bring valuables with you to the facility**