



Central Referral Office
Community Healthcare Organisation – Dublin North City & County
Nexus Building, Unit 1 & 2,
Blanchardstown Corporate Park,
Dublin 15
D15 CF9K
Phone Number: **01 8975153**
Email: **cro.dncc@hse.ie**

Adult Primary Care Services Referral Form

All fields highlighted with an asterisk (*) are mandatory.

Please note that Adobe Acrobat software is required to use the Submit function on this form.

GPs please Note:

You can now access a referral form for Adult Primary Care services on Healthlink.

Date of Referral*

Please use format DD/MM/YYYY

Primary Care Services you wish to refer to*

Dietetics (Health & Social Care Professional Referral only)	<input type="checkbox"/>	Physiotherapy	<input type="checkbox"/>
Speech & Language Therapy	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>
Social Work	<input type="checkbox"/>	Psychology	<input type="checkbox"/>
Nursing	<input type="checkbox"/>		

Client Personal Details

Surname*

First Name*

Gender*

Other

Date of Birth*

IHI

PPS Number*

Medical Card Number

Mobile/Phone*

Email

Mother's Maiden name*

Consent to receive appointment reminder or contact by Text Message:*

Yes

No

Address Line 1*

Address Line 2*

Address Line 3

County* Eircode

Country of Birth

First Language* Other

Other languages spoken at home

Interpreter required* Yes No

Please specify language

Next of Kin

Surname First Name

Relationship

Mobile Email

Support services used outside of Primary Care:*

None	<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/>
ICPOP	<input type="checkbox"/>	Home Help	<input type="checkbox"/>
Meals on Wheels	<input type="checkbox"/>	Daycare	<input type="checkbox"/>
ICPCD	<input type="checkbox"/>	Respite	<input type="checkbox"/>

General practitioner details

Surname*

First Name*

GP Practice*

GP Telephone*

Email*

Address Line 1*

Address Line 2*

Address Line 3

County*

Eircode

Reasons for referral/Anticipated Outcome*

Referrer details

Surname*

First Name*

Source of Referral*

Health Professional Registered No. (HPRN) e.g., NMBI/CORU/MRN

Address Line 1*

Address Line 2*

Address Line 3

County*

Eircode

Mobile/Phone*

Email*

Please indicate whether referrer should be contacted prior to the initial appointment: Yes

No

Are there any relevant risk factors in relation to this referral?

Medical history

(Please Attach any relevant Medical Reports)

Previous hospital attendance

Unknown

History of Presenting Complaints*

History of Past Illness

History of Surgical Procedures

Allergies/Adverse medication events

Relevant Family History

Social History

Social
Circumstances*

Impaired Vision*

Impaired Hearing*

Has this patient
fallen in the last
6/12 months?*

Mobility*

Aids Used

Transfers*

Cognitive
Concerns

Drinker

Smoker

Current Medication

Patient on
Anticoagulants?

Current
Medication

Complete for relevant discipline(s) you are referring to:

Nursing Referrals

Continence problem	<input type="checkbox"/>	Chronic illness management	<input type="checkbox"/>
Health education/promotion	<input type="checkbox"/>	Home supports	<input type="checkbox"/>
Leg ulcer	<input type="checkbox"/>	Wound care	<input type="checkbox"/>
Nursing assessment	<input type="checkbox"/>	Preventative care	<input type="checkbox"/>
Hospital discharge	<input type="checkbox"/>	Palliative care	<input type="checkbox"/>
Other	<input type="checkbox"/>		

Dietician Referrals (Referral needs to be made by Health & Social Care Professional)

Pre-diabetes/diabetes	<input type="checkbox"/>	Recent weight loss/low weight/ malnutrition	<input type="checkbox"/>
Dysphagia (SLT Assessed)	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	Stoma	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Overweight/Obesity	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Heart Health	<input type="checkbox"/>
Coeliac	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Inflammatory Bowel Disease	<input type="checkbox"/>	Other	<input type="checkbox"/>

Speech and Language Referrals

Does the patient have any of the following communication difficulties?:

Receptive language difficulties	<input type="checkbox"/>	Expressive language difficulties	<input type="checkbox"/>
Voice Dysarthria	<input type="checkbox"/>	Dyspraxia	<input type="checkbox"/>
Stammering	<input type="checkbox"/>	Memory difficulties	<input type="checkbox"/>

Does the patient have any of the following eating, drinking or swallowing difficulties?:

Dysphagia	<input type="checkbox"/>	Concerns re aspiration	<input type="checkbox"/>
Choking	<input type="checkbox"/>	Difficulty managing fluids	<input type="checkbox"/>
Difficulty managing food	<input type="checkbox"/>	Difficulty managing fluids and food	<input type="checkbox"/>
Difficulty swallowing tablets	<input type="checkbox"/>		

Does the patient have any food allergies?

Physiotherapy Referrals

Difficulty with transfers in and out of bed	<input type="checkbox"/>	Difficulty with transfers in and out of chair	<input type="checkbox"/>
Difficulty with walking inside	<input type="checkbox"/>	Difficulty with walking outside	<input type="checkbox"/>
Difficulty with walking on stairs or steps	<input type="checkbox"/>		

Occupational Therapy Referrals

Activities of daily living	<input type="checkbox"/>	Access to property & safety issues	<input type="checkbox"/>
Carer support & education	<input type="checkbox"/>	Pressure care	<input type="checkbox"/>
Falls	<input type="checkbox"/>	Wheelchair/seating	<input type="checkbox"/>
Cognitive/perceptual	<input type="checkbox"/>	Mental health concerns	<input type="checkbox"/>
Moving, handling & transfers	<input type="checkbox"/>	End of life/palliative care	<input type="checkbox"/>

Social Worker Referrals

Access Services	<input type="checkbox"/>	Advocacy	<input type="checkbox"/>
Carer Support	<input type="checkbox"/>	Dementia	<input type="checkbox"/>
Financial Support	<input type="checkbox"/>	Home Environment	<input type="checkbox"/>
Information & Advice	<input type="checkbox"/>		

Psychology Referrals

Anxiety	<input type="checkbox"/>	Relationship difficulties	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Coping with injury/illness	<input type="checkbox"/>
Life cycle development issues	<input type="checkbox"/>	Stress & trauma	<input type="checkbox"/>
Adjustment problems	<input type="checkbox"/>	Bereavement	<input type="checkbox"/>

Additional relevant information

Consent*

Referral Consent: Has the individual being referred consented to this referral and has this been documented? Yes No

I give permission to Primary Care Services to contact and obtain relevant information pertaining to my referral from other services/agencies involved in my care. Yes No

I give permission that in the event that this referral is not appropriate it may be shared with other relevant services to facilitate an onward referral. Yes No

GDPR Consent: I give permission for my information to be held by Primary Care Services in accordance with obligations under the Data Protection Acts 1988, 2003 and 2018. Yes No

Submit