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Health in The Home Referral Form

Patient details

Title: _____ First name: _____ Surname: _____

Address: _____

Date of birth (dd/mm/yy): _____ Mobile Tel. No.: _____ Home No. or Email: _____

Hospital No: _____ Ward: _____ Bed No: _____

Diagnosis: _____

Allergies: _____ Weight: _____

Reason for Referral: (1) _____

Reason for Referral: (2) _____

Consultant details

Title: _____ First name: _____ Surname: _____

Hospital: _____ Speciality: _____

Phone Number: _____ Email: _____

Medication and Administration

No.	Medication (Including intravenous fluids)	Calculated Dose	Route	Frequency	Duration of Infusion (Mins)	Anticipated Start Date & Dose	End Date & Dose
1							
2							
3							

Wound Dressing Details

Negative Pressure Dressing Type	Frequency of Dressing	Foam Size	Foam Type	Pump No. and Pressure	Pump Action
Vac <input type="checkbox"/>	Once week <input type="checkbox"/>	Small <input type="checkbox"/>	Black <input type="checkbox"/>	No.:	Continuous <input type="checkbox"/>
Rehensys <input type="checkbox"/>	Twice week <input type="checkbox"/>	Medium <input type="checkbox"/>	White <input type="checkbox"/>	mhg:	Intermediate <input type="checkbox"/>
Pico <input type="checkbox"/>	Three times per week <input type="checkbox"/> Other <input type="checkbox"/>	Large <input type="checkbox"/>	Silver <input type="checkbox"/>		

Conventional dressing plan: _____

Wound measurements: _____

Plan attached: _____

Emergency Medication Requirements

The medications listed below will only be administered to treat an infusion related reaction.

Medication	Dose	Route
Epinephrine (Adrenaline)	500mcg	IM PRN x 2 (10-15 min apart for more severe reactions)
Chlopheniramine	10mg	10-20mg IM or slow IV over 1 min PRN x 1 for severe reaction
Hydrocortisone	200mg	IV PRN x 1 for severe reaction
Prescriber Signature:	Bleep No:	Date(dd/mm/yy):
_____	_____	_____

Health in The Home Referral Form

Policyholder details

Title: _____ First name: _____ Surname: _____
 Date of birth (dd/mm/yy): _____ Policy No: _____

Specimens Required

Type of bloods required: _____
 Preferred Day and Frequency of Bloods required: Monday Tuesday Wednesday Thursday Friday
 Most Recent Bloods: (or attach separately) _____

Medical professionals and NOK details

Liaison Nurse:	Liaison Nurse Contact details:
GP Name:	GP Address:
GP Contact Ph. No.:	
Next of Kin Name:	Next of Kin Contact details:
Next of Kin Relationship:	

Medical history and details

Clinical Observations on date of referral:

B/P:	HR:	Temp:	RR:	SaO ₂ :
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Investigations completed in hospital: _____

Past History: _____

Current Medications: _____

Any other information in relation to treatment within the home: _____

Please confirm that the patient has had a minimum of ONE Infusion within the hospital setting Yes No

Does the patient have a line insitu? Yes No Type of line: PICC Port Cannula Date Inserted (dd/mm/yy): _____

I confirm that the line has been reviewed and is safe for use at home
 Please tick

I also confirm that a date will be confirmed with Next of Kin for removal of CVAD
 post treatment completion date
 Please Tick

Health in The Home Referral Form

Health Care professional Declaration:

To be completed by the health care professional:

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the e TCP Homecare Privacy Statement which can be found at <https://www.tcp.ie/pages/privacy-statement>

Referring Health Care Professional in BLOCK CAPITALS:

Referring Health Care Professional Signature:

Date: (dd/mm/yy)

Contact details:

Patient Declaration:

To be completed by the patient:

I authorise the consultant/doctor referred to in this form to furnish TCP Homecare (being Temperature Controlled Pharmaceuticals Limited) with this form and its contents. I acknowledge that TCP Homecare is collecting the information in this form for the purpose of delivering treatment and I agree to the disclosure by TCP Homecare of this form and its contents to Irish Life Health as an independent data controller for the purposes of assessing whether my applicable policy with Irish Life Health entitles me to participate in treatment in the home in respect of the particular medication, administration and any other aspect of care stated in this form, whether I am eligible for such treatment and to determine whether to engage TCP Homecare to provide such treatment to me

Patient Signature:

Date: (dd/mm/yy)

