TCP Homecare

Irish Life health

Email: Healthinthehome@irishlifehealth.ie | ilh@tcp.ie

Health in The Home Referral - Hyperemesis Pathway 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: Height: BMI:

Reason for Referral:

Consultant details

Title: First name: Surname:

Hospital: Speciality:

Phone Number: Email:

Medication and Administration

No.	Medication	Calculated Dose	Route	Frequency	Duration of Infusion (Mins)	Anticipated Start Date & Dose	End Date & Dose
1							
2							
3							
4							

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)

Prescriber Signature:	Medical Council Number	Bleep No:	Date(dd/mm/yy):

Pregnancy details *please refer to Inclusion/exclusion criteria below

Gestation: Date of last scan:

Name/Date/Dose of first Intravenous Medications for hyperemesis:

Name: Date: Dose:

Please indicate category of pregnancy: High Risk ☐ Low Risk ☐

Details:

Next OPD appointment date:

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Policyholder details

Title: First name: Surname:

Date of birth (dd/mm/yy): Policy No:

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 information

Investigations completed in hospital:

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

Past History:

Current Medications:

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 ☐

Referring Doctor's Signature:	Medical Council Number	Date (dd/mm/yy):

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Health in The Home Referral - Hyperemesis Pathway Form

Health Care professional Declaration:

***Inclusion criteria for Hyperemesis pathway**

- USS scan completed prior to referral to out rule molar and twins.
- At least one IV given at a hospital prior to home care and monitored for reactions- that could be ED /inpatient/day ward (this could have been in a previous pregnancy for multip).
- Current accurate weight and height needed. Patient must have own weighing scales in their home if this is required pre and post IV fluids.
- Referrals for woman up to 20 weeks gestation *please note referrals can take up to one week to process.
- Low risk pregnancy only to be accepted onto service.
- IM anti emetics can be referred onto service for nurses to administer
- Iv fluids/IM anti emetics once/twice weekly up to 4 weeks at a time then medical review again required.

***Exclusion criteria for Hyperemesis pathway**

- High BMI/ bariatric and low BMI<18 not suitable.
- Multiples pregnancy (twins, triplets etc)
- High risk pregnancy requiring regular medical intervention/obstetrician care over midwifery lead care. All referrals are clinically screened prior to treatment.
- Woman past gestation of 20 weeks not suitable for referral. *Please note referrals can take up to one week to process.
- Once gestation period is 20 weeks patient will be discharged off service and revert to Hospital care.

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:

Medical Council Number/Pin:

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)

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Notes: