**(Please Complete in Block Capitals)**

**All correspondence should be sent to** [**isolation.facility@hse.ie**](mailto:isolation.facility@hse.ie)

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

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| --- | --- | --- | --- | --- | --- |
| **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 No  Date 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 Unknown  Date of vaccination:  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | |
| **Reason for Referral *i.e. reason they are unable to self-isolate at home, please be specific:*** | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Background Information** | Smoker:  Yes No  Drug Dependency:  Yes No  Alcohol Dependency  Yes No  Psychiatric Illness  Yes No  Seizures/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**