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)	☐	Physiotherapy	☐
Speech & Language Therapy	☐	Occupational Therapy	☐
Social Work	☐	Psychology	☐
Nursing	☐		

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	☐	Mental Health Services	☐
ICPOP	☐	Home Help	☐
Meals on Wheels	☐	Daycare	☐
ICPCD	☐	Respite	☐

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	☐	Chronic illness management	☐
Health education/promotion	☐	Home supports	☐
Leg ulcer	☐	Wound care	☐
Nursing assessment	☐	Preventative care	☐
Hospital discharge	☐	Palliative care	☐
Other	☐		

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

Pre-diabetes/diabetes	☐	Recent weight loss/low weight/ malnutrition	☐
Dysphagia (SLT Assessed)	☐	Irritable Bowel Syndrome	☐
Anaemia	☐	Stoma	☐
Constipation	☐	Overweight/Obesity	☐
Cancer	☐	Heart Health	☐
Coeliac	☐	Osteoporosis	☐
Inflammatory Bowel Disease	☐	Other	☐

Speech and Language Referrals

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

Receptive language difficulties	☐	Expressive language difficulties	☐
Voice Dysarthria	☐	Dyspraxia	☐
Stammering	☐	Memory difficulties	☐

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

Dysphagia	☐	Concerns re aspiration	☐
Choking	☐	Difficulty managing fluids	☐
Difficulty managing food	☐	Difficulty managing fluids and food	☐
Difficulty swallowing tablets	☐		

Does the patient have any food allergies?	

Physiotherapy Referrals

Difficulty with transfers in and out of bed	☐	Difficulty with transfers in and out of chair	☐
Difficulty with walking inside	☐	Difficulty with walking outside	☐
Difficulty with walking on stairs or steps	☐		

Occupational Therapy Referrals

Activities of daily living	☐	Access to property & safety issues	☐
Carer support & education	☐	Pressure care	☐
Falls	☐	Wheelchair/seating	☐
Cognitive/perceptual	☐	Mental health concerns	☐
Moving, handling & transfers	☐	End of life/palliative care	☐

Social Worker Referrals

Access Services	☐	Advocacy	☐
Carer Support	☐	Dementia	☐
Financial Support	☐	Home Environment	☐
Information & Advice	☐		

Psychology Referrals

Anxiety	☐	Relationship difficulties	☐
Depression	☐	Coping with injury/illness	☐
Life cycle development issues	☐	Stress & trauma	☐
Adjustment problems	☐	Bereavement	☐

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