

Neurosurgery referral to CHI at Temple St

Please complete the required areas below and email form to: ***neurosurgery.calls@childrenshealthireland.ie***

Please ensure you contact Neurosurgery registrar/clinical nurse specialist to discuss the patient and to inform them of the referral.

\*\*\*\*\*\***EMAILING THIS FORM ALONE WITHOUT CONTACTING NEUROSURGERY BY PHONE DOES NOT CONSTITUTE A REFERRAL\*\*\*\*\*\*\*\*\***

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| --- | --- |
| **Date and time of referral** |  |
| **Patient details:**  **Name:**  **Address:**  **Date of birth:**  **Medical record number of referring hospital:**  **Name of Guardian:**  **Contact number:** |  |
| **Referring hospital and patient location at time of referral** |  |
| **Referring doctor: Name, IMC and contact number** |  |
| **Referring consultant:** |  |
| **Reason for referral** |  |
| **Relevant history+ examination**  **please include relevant medications,**  **GCS,**  **Pupillary reaction,**  **Fasting time (if relevant)** |  |
| **Imaging**: |  |

**Neurosurgery use only:**

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| --- | --- |
| **Date and time of referral** |  |
| **Neurosurgery Registrar on call** |  |
| **Consultant on call/ Consultant case was discussed with** |  |
| **Outcome/ Recommendation** |  |
| **Neurosurgery section completed by:** |  |