

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:**  |  |