NATIONAL ORTHOPAEDIC HOSPITAL CAPPAGH	RF-OPD-1:	
	Revision Number:	
	Issue Date:	
	Next Review:	
National Orthopaedic Hospital Cappagh, Finglas, Dublin 11.	Affix Addressograph here: (hospital use only)	
OUT-PATIENT REFERRAL FORM		

PATIENT DETAILS				
Medical Record Number:			Gender:	
Date of Birth:			Mobile Number:	
Name:			Home Number:	
Street:			GP Name:	
Town:			Next of Kin	
Country:			First Language:	
Intrepreter or Communication Assistance Required:	Yes	No	Details:	
Wheelchair Assistance:	Yes	No		
Repeat CNOH Patient:	Yes	No		

HEALTH INSURANCE DETAILS			
Provider:		Policy Number:	

REFERRAL INFORMATION	
Referral Date:	
Priority:	Urgent Soon Routine
Reason For Referral/ Anticipated Outcome:	
Symptoms: (including history of presenting complaint and interventions to date)	
Examination Findings:	
Relevant Tests/ Investigations to Date:	
Past Medical History:	
Current Medication:	
Adverse Events/ Allergies:	
Relevant Family History:	
Home Circumstances: (i.e. lives alone or with family/spouse, 2 storey/bungalow/flat, what floor, support services involved - meals on wheels, carer, home help etc)	
Additional Relevant Information: (including special needs, disabili es and clinical warnings)	

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MEDICAL HISTORY (check details with patient)					
Asthma/COPD:	**Yes**	**No**	**Past Anaesthetic Problems:**	**Yes**	**No**
Diabetes:	**Yes**	**No**	**Allergies:**	**Yes**	**No**
Angina/MI:	**Yes**	**No**	**Anti-coagulants:**	**Yes**	**No**
CVA:	**Yes**	**No**	**HRT/OCP:**	**Yes**	**No**
Hypertension:	**Yes**	**No**	**Dental Review Required:**	**Yes**	**No**
Additional Comments:					

REFERRER DETAILS	
Name:	
Address:	
Telephone Number:	
Fax Number:	
Signature of Referrer:	
Date:	
Medical Council Number:	

FOR HOSPITAL-USE ONLY	
Date Referral Received:	
Date Sent For:	
Consultant Triage:	
Consultant:	
MSK Triage Required: (to be completed by consultant)	
Date Returned From:	
Consultant Triage:	
Date Of New Attendance:	
Date Patient Contacted:	
MSK Clinic:	
Consultant Clinic:	