Outpatients - GP Referral Form
Our Lady's Children's Hospital, Crumlin®

Ospidéal Mhuire na Leanaí, Cromghlinn
Our Lady's Children's Hospital, Crumlin

Referral Date: _____

Department:_____Consultant/Specialty:_____

Referral Type:_____

Patient Personal Details

Surname: _____ Forename: _____

DOB:_____ Male/Female:_____

Address:_____

_____

Parents/Guardian Name:_____

_____

Main Telephone Number:_____ Mobile Number:_____
(please note this mobile number will be used to send a text reminder to patient to attend the appointment)

GP/Referral Source Details

Referring GP:_____

Practice Name:_____

Address: _____

_____

Tel No:_____ Fax:_____

Email:_____

Please Provide Official GP/Source of Referral Stamp below

Clinical Details

Reason for Referral

History of Complaint

Relevant Clinical Examination

Background History

Medications

Allergies

Comments/Remarks

THIS SECTION IS FOR HOSPITAL OFFICIAL USE ONLY

Date referral received:
Date Triaged:
If rejected please state reason_____

Triage Outcome:
Urgent □ Soon □ Routine □