



**Outpatients - GP Referral Form**  
**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

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History of Complaint

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Relevant Clinical Examination

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Background History

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Medications

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Allergies

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Comments/Remarks

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**THIS SECTION IS FOR HOSPITAL OFFICIAL USE ONLY**

Date referral received:

Triage Outcome:

Date Triaged:

Urgent       Soon       Routine

If rejected please state reason \_\_\_\_\_