Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National CIT Referral Form

CIT Phone: 087-9792589
CIT Fax: 01 4987132
ALL FIELDS MUST BE COMPLETED

Patient Details

Surname: Forename: DOB:	Sex: ☐ Male ☐ Female Address/Discharge Address:	Next of Kin (NOK) Name: NOK Relationship & Contact No.
Pt Contact Number:	GMS/DPS/LTI/PPSN:	Living Alone? ☐ **Yes** ☐ **No**

Referring Source Details

Referring person & location	Date of referral	Time of referral

Ward & MRN (Medical Records Number)	Admission date to hospital	Consultant

Date to be seen by CIT	GP Name	GP Address & contact details

Discharge referral sent to: ☐ GP ☐ Physio ☐ PHN ☐ OT	Known allergies

Relevant Medical/Surgical/Psychiatric history, treatment received & current diagnosis

Copy of prescription supplied? ☐ **Yes** ☐ **No**	Has patient/NOK consented to CIT service & sharing of information? ☐ **Yes** ☐ **No**	Infection Control Status, MRSA, C-Diff, VRE, Other?
Mobility Status	Cognitive Status ☐ Orientated ☐ Confused	Reason for referral to CIT

Current vital signs HR __________ BP ___________ SpO2 ________ LTOT Y / N RR __________ Temp__________

Any additional Information/ Comments	

For CIT Office Use

Has patient been informed of the option to attend CIT clinic for treatment?	☐ **Yes** ☐ **No**
Are there any safety issues CIT staff need to be aware of for home visits?	☐ **Yes** ☐ **No**

Any additional CIT Office Information/ Comments	

DO NOT DISCHARGE A PATIENT UNTIL YOU RECEIVE CONFIRMATION BACK FROM CIT THAT THEY CAN ACCEPT THE CARE OF YOUR PATIENT