TCP Homecare

Irish Life health

Health in The Home Referral Form

Patient details

Title: First name: Surname:

Address:

Date of birth (dd/mm/yy): Mobile Tel. No.: Home No. or Email:

Hospital No: Ward: Bed No:

Diagnosis:

Allergies: Weight:

Reason for Referral: (1)

Reason for Referral: (2)

Consultant details

Title: First name: Surname:

Hospital: Speciality:

Phone Number: Email:

Medication and Administration

No.	Medication	Calculated Dose	Route	Frequency	Duration of Infusion (Mins)	Anticipated Start Date & Dose	End Date & Dose
1							
2							
3							

Negative Pressure Dressing Type	Frequency of Dressing	Foam Size	Foam Type	Pump No. and Pressure	Pump Action	Dressing Plan
Vac ☐	Once week ☐	Small ☐	Black ☐	No.:	Continuous ☐	
Renesys ☐	Twice week ☐	Medium ☐	White ☐		Intermediate ☐	
Pico ☐	Three times per week ☐ Other ☐	Large ☐	Silver ☐	mhg:		

I authorise the consultant/doctor referred to in this form to furnish TCP Homecare (being Temperature Controlled Pharmaceuticals Limited) with this form and its contents. I acknowledge that TCP Homecare is collecting the information in this form as an agent of Irish Life Health and I agree to the disclosure by TCP Homecare of this form and its contents to Irish Life Health. I also agree that Irish Life Health may use the information in this form to assess whether my applicable policy with Irish Life Health entitles me to participate in treatment in the home in respect of the particular medication, administration and any other aspect of care stated in this form, whether I am eligible for such treatment and to determine whether to engage TCP Homecare to provide such treatment to me.

Print patient name in block capitals:	Patient Signature:	Date(dd/mm/yy):

Administration:	To be administered by a TCP Homecare Nurse in accordance with the SmPc

Emergency Medication Requirements

The medications listed below will only be administered to treat an infusion related reaction.

Medication	Dose	Route
Epinephrine (Adrenaline)	500mcg	IM PRN x 2 (10–15 min apart for more severe reactions)
Chlopheniramine	10mg	10–20mg IM or slow IV over 1 min PRN x 1 for severe reaction
Hydrocortisone	200mg	IV PRN x 1 for severe reaction

Prescriber Signature:	Bleep No:	Date(dd/mm/yy):

Continued on page 2

TCP Homecare

Irish Life health

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Policyholder details

Title: First name: Surname:

Date of birth (dd/mm/yy): Policy No:

Specimens Required

Monday	Tuesday	Wednesday	Thursday	Friday

Type of bloods required

Most Recent Bloods: (or attach separately)

Clinical Observations on date of referral:

B/P:	HR	Temp:	RR:	SaO_2

Liaison Nurse:	Liaison Nurse Contact details:

GP Name:	GP Address:
GP Contact Ph. No.:	

Next of Kin Name:	Next of Kin Contact details:
Next of Kin Relationship:	

Investigations completed in hospital:

Any other information in relation to treatment within the home:

Please confirm that the patient has had a minimum of ONE Infusion within the hospital setting ☐ Yes ☐ No

Past History:

Current Medications:

Does the patient have a line insitu? ☐ Yes ☐ No

Type of line:	I confirm that the line has been reviewed and is safe for use at home Please tick ☐	I also confirm that a date will be confirmed with Next of Kin for removal of CVAD post treatment completion date Please Tick ☐	Date Inserted (dd/mm/yy):

Referring Doctor's Signature:	Date (dd/mm/yy):

Continued on page 3

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Irish Life health

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Health Care professional Declaration:

To be completed by the health care professional:

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the e TCP Homecare Privacy Statement which can be found at https://www.tcp.ie/privacy-statement

Referring Health Care Professional in BLOCK CAPITALS:

Referring Health Care Professional Signature: Date: (dd/mm/yy)

Contact details:

Patient Declaration:

To be completed by the patient:

I authorise the consultant/doctor referred to in this form to furnish TCP Homecare (being Temperature Controlled Pharmaceuticals Limited) with this form and its contents. I acknowledge that TCP Homecare is collecting the information in this form for the purpose of delivering treatment and I agree to the disclosure by TCP Homecare of this form and its contents to Irish Life Health as an independent data controller for the purposes of assessing whether my applicable policy with Irish Life Health entitles me to participate in treatment in the home in respect of the particular medication, administration and any other aspect of care stated in this form, whether I am eligible for such treatment and to determine whether to engage TCP Homecare to provide such treatment to me

Patient Signature: Date: (dd/mm/yy)

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Notes: