Step Up Step Down Intermediate Care Unit
34 Amberley House
Gardiner St
North Dublin City
Tel: (01) 649 8604/ 09

Secure email: SUSD@healthmail.ie

Referral Form

CONSENT (GDPR requirement):

By Checking this box, I, *(referrer)* _____, confirm that I have received written consent from the client, *(name of client)* _____ to share the above personal data with you and that this written consent is stored securely within our service

Referrer name: _____

Date: _____

Criteria for Admission

- Homeless and or recently homeless and engaging with Homeless service providers.
- Male and female over the age of 18 years
- Medical Conditions that are resolvable/stabilised within under 3 weeks. Applies to mental and physical health conditions.
- Pre inpatient work up / preparation
- Observation / convalescence
- Recuperation post hospital discharge

Clinician (Nurse or GP) letter

Client First Name: **Surname:**

Date of Birth:

Male ☐ **Female** ☐

Address :

Step Up ☐

Step Down ☐ Name of hospital and ward: Ward contact:

Allergies:

Primary Reason for Admission:

PLEASE ATTACH ANY RECENT HOSPITAL DISCHARGE PAPER WORK/PRESCRIPTIONS/LAB RESULTS ETC THAT YOU HAVE. THANK YOU.

***Mobility:** **Does this client currently have mobility aids? Yes** ☐ **No** ☐

Can this client use the stairs? Yes ☐ **No** ☐

Medical / Psychiatric History:

(Prompts: seizures (type, frequency), diabetes, wound care, depression, psychosis that is being treated etc.)

***Are you currently engaged with any mental health service? yes** ☐ **No** ☐

If yes which services: _____

Current Medication, dose, frequency:

GP Name: _____, Contact Number_____.

Address: _____.

Methadone Dispensing Pharmacist:

Address: _____Phone:

Email:

Client Details –

Accommodation Type: **Client's current contact address:** **Client's contact number:** **Do you know if the agency will hold the bed while client is in Step Up Down Unit Y ☐ N ☐**	**Country of origin:** **Level of spoken English (if relevant)** **Do you have an up to date Medical card?** **Y ☐ N ☐**
Alcohol History (if applicable) Type of alcohol consumed : (e.g.) VODKA Amount per Day:	**Drug History (if applicable)** Type(s) of drugs used: Amount per Day : How are drugs taken? Frequency of use in last month: (P.O; IV; Smoked; Snort; Skin; Pop)

Submitting Referral form
Please note, we cannot process your client for admission if the form is incomplete or relevant additional detail is not included with the referral form. This may lead to delays in your client being admitted.

Submit referral form to the Unit via one of the following means:
1. Secure health-mail ONLY
2. Hand delivered to the unit.
3. Registered Post

Things you need to know before admission

(1) Visitors are not permitted to the Unit to promote a safe and recovery focused environment.
(2) This admission may not lead to a change in your accommodation status.
(3) We expect you to comply with your treatment.

I confirm this patient is suitable for admission to the residential Step Up Step Down – Intermediate Care Centre)
Name of referring Clinician (in block capitals):_____

Signature of referring Clinician: _____Date: _____
GP MCN no: _____Clinician address and contact no:
_____