INTERNATIONAL REFERRAL FORM

Bupa CROMWELL HOSPITAL

Thank you for referring your patient to us and we are hoping we will be able to assist you in meeting the needs and expectations for you, the patient and their family.

In order for us to be able to ensure that we provide safe and effective care, we require the following information. This is needed so that we can accurately assess the specific needs of the patient before they arrive. This will allow us to make the appropriate and necessary preparations.

AFFIX PATIENT LABEL HERE

Name of referring consultant:		
Patient's first name:	Surname:	
Date of birth:	Age:	
Are they presently: in hospital ☐ at home ☐ other_____		
Weight:	History of weight loss:	Height:
Length of stay in Hospital:		
History of Current Illness:		
Medication History: (please provide a copy of the most recent drug chart)	Airway:	
Breathing: (please provide latest chest X-Ray report)	Circulation:	
Neurology:	Mobility: (any aids required)	
History of any of the following infection risks: MRSA: Y ☐ N ☐ MDR Gram Negative organisms Y ☐ N ☐ Cdifficile Infection: Y ☐ N ☐ Norovirus: Y ☐ N ☐ TB: Y ☐ N ☐		
Recent set of Blood results:		
Diet: NG ☐ PEG ☐ Oral ☐	Intravascular access site:	

Diet: NG ☐ PEG ☐ Oral ☐	Intravascular access site:
Please give details of indwelling devices (intravenous and urinary catheters)	

Type of device	Position (where applicable)	Date of Insertion

Activities of Daily living: