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**National Paediatric Facial Palsy Centre**

**Temple Street Children’s University Hospital**

**Temple Street**

**Dublin 1**

**Referral to Mr Christoph Theopold and Mr Dylan Murray, Consultant Plastic Surgeons**

**Patient Details**

|  |  |
| --- | --- |
| Name: | Nationality: |
| DOB: | First Language:Interpreter required: Y/N *( please circle)* |
| Address: | Parents Names: Telephone Numbers: |

**Medical Details**

|  |
| --- |
| Reason for Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Birth History: Gestation:  Medical History/ Co-Morbidities:Weight: Height:  |
| Family History:  |

**Referring Professional Information**

|  |  |
| --- | --- |
| Name of Referrer: | Source of Referral: Hospital/Centre/PracticeAddress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Consultants Name: | Telephone:Fax: |
| Specialty: Neonatologist Oncologist Paediatrician ENTNeurosurgeon Ophthalmology  Neurologist Other  | Email:Office use only:Date received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Triaged: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**THE NPFPC DOES NOT REQUIRE RADIOLOGY IMAGING TO PROCESS THIS REFERRAL, HOWEVER IF ALREADY COMPLETED PLEASE SEND A COPY ON DISK AND A PRINTED RADIOLOGY REPORT**.

**Email:** **facial****palsy@cuh.ie or Fax: 01 892 1820 Telephone No: 01 878 4883**