

National Paediatric Craniofacial Centre,  
Temple Street Children's University Hospital,  
Temple Street,  
Dublin 1.



Referral to Mr Dylan Murray, Consultant Craniofacial, Plastic & Reconstructive Surgeon

## Patient Details

Patient Name

Nationality

Date of Birth

First Language

Sex (please tick)

Male

Female

Interpreter required?

Address

Parents Names

Telephone Numbers

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

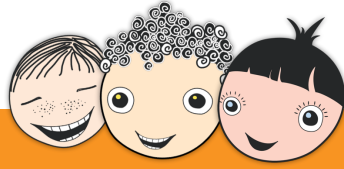
Email: [craniofacial@cuh.ie](mailto:craniofacial@cuh.ie) or Fax: 01 892 1820

Telephone No: 01 878 4883

Ref. TAC / NPCC IMJ Jan 2016

revised: Oct 2016

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## Medical Details

Date of Referral

Reason for Referral

Birth History

Single Birth (please tick)

Yes  No

Multiple Birth (please tick)

Yes  No

Gestation

Birth Weight

Height

Head Circumference

(Please include copy of growth chart)

Medical History / Co-Morbidities:

Current weight

Height

Head Circumference

(Please include copy of growth chart)

Affected Parents (please tick)

Yes  No

Affected Siblings (please tick)

Yes  No

Diagnosis of affected family member:

Maternal Age

Paternal Age

All referrals must be accompanied by photographs failure to do so will result in a delay in triaging /rejection of referral.

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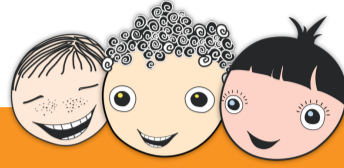
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## Referring Professional Information

Name of Referrer

Source of Referral: Hospital / Centre / Practice Address

Consultant's Name

Telephone

Fax

Email

Specialty (please tick)

Neonatologist	<input type="checkbox"/>	AMO	<input type="checkbox"/>	Paediatrician	<input type="checkbox"/>
Neurosurgeon	<input type="checkbox"/>	GP	<input type="checkbox"/>	<hr/>	

Date received

Date Triaged

Office use only

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