St. Mary's Rapid Access

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Name: _____

Address: _____

_____

_____

DOB: _____

Contact Numbers: Mobile _____ Home _____

Name & Contact of family member if appropriate: _____

_____

Presenting conditions: _____

_____

_____

Relevant Med History: *(Please attach any resent bloods results, diagnostic reports, discharge forms etc with referral form)*

_____

_____

_____

_____

Relevant Surgical History:

_____

_____

_____

Allergies: _____

Medications:

Or fax patients last prescription

Additional Comments for the attention of the Consultant Geriatrician: _____

_____

Doctor Stamp: ***Contact Details:***

Patients will be offered appointments within 72 hours of the referrals being received

Please fax referral to: (01) 657 9035

Please include copies of relevant tests done or hospital letters

Telephone: (01) 6579000

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