



Ear, Nose & Throat Referral Form

- Outpatients Referral:** Fax this form to 01 6785462 or post to Outpatients Dept
- Emergency Referral:** Give patient letter of referral to bring to A&E Dept

From: Name of GP:	Address:
Tel no:	Date of Referral:

Patient Details: Name:	DOB:	Gender:
Address:	Tel No (home):	
Post code:	Tel No (work/mobile):	
Medical Card Number:	Interpreter required Yes No If Yes, First language:	
	Special needs Yes No if yes please give details	
Health Insurance Company:	Insurance No.	Plan:

Has this patient previously visited this hospital? Yes No

Referring patient to:

Examination / Reason for referral:

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Other Information: Medical Hx, Family Hx, Current Medication, treatments to date:

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<p><i>PRACTICE STAMP AND M.C.N.</i></p>

<p><i>HOSPITAL USE ONLY</i></p> <p>ASSESSED BY:</p> <p>OUTCOME:</p> <p>Urgent Routine Soon</p>
