Beacon Hospital

MINOR PROCEDURES REFERRAL FORM

TEL: 01 2938652 / 01 2938650. FAX: 01 2938619.

PATIENT DETAILS

Patient's Name | D.O.B.

Address | Home Telephone

Mobile

GP DETAILS

Name of Referring Doctor | Surgery Telephone

Surgery Address | Fax

Email

PRIORITY

Soon ☐ Routine ☐

MEDICAL INSURANCE

Company: VHI ☐ AVIVA ☐ Quinn ☐ Other ☐ Self Pay ☐

ESSENTIAL QUSTIONS

Is the patient on any of the following: Warfarin ☐ Aspirin ☐ Plavix ☐

Indication for treatment:

If on Warfarin, have INR done prior to procedure.

Is the patient Diabetic? ☐ Yes ☐ No

If 'Yes' please tick as appropriate ☐ Type 1 ☐ Type 2

Procedure Required

INDICATION

Pain

Duration of Symptoms

Past Medical History

Current Medications

Pathology Required? ☐ Yes ☐ No

Send Results to: