Public Gynaecology Referral Form

Please send the completed form to: The Central Appointments office, Rotunda Hospital, Dublin 1.
Email: apptscheduling@rotunda.ie **Fax No:** 01 8172514 **Office Phone No**: 01 8171758

PATIENT DETAILS:

Patient Name:_____

Patient address:_____

_____

Patient Date of Birth:_____

Contact Phone No:_____

Interpreter needed: Yes / No

Language:_____

Next of Kin name:_____

Next of Kin address:_____

_____

Next of Kin contact phone number:_____

Consent to text message patient: Y / N

Special needs: Yes / No Details:_____

Has the patient attended this hospital before: Y / N

REFERRER DETAILS:

Name of Referring Doctor:_____

IMC No. of referring Doctor:_____

Address of referring Doctor:_____

Contact No of referring Doctor:_____

Date of referral:_____

Patients GP (if different)_____

GP address:_____

Contact phone no:_____

Priority request: Routine / Urgent (please circle)

REFERRAL DETAILS:

Specialty requested:

General	( )
Adolescent	( )
Infertility	( )
Promotion of Continence	( )
GP Led Evening Clinic	( )
Hysteroscopy	( )

Indication for referral:

Please enclose all current test results with referral
All listed medications to accompany referral