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:_______________________

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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