

Rapid Access for the older person

Name: _____

Address: _____

DOB: _____

Contact Numbers: Mobile _____ Home _____

Name & Contact of family member if appropriate: _____

Presenting conditions: _____

Relevant Med History: (Please attach any recent 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

Email: medical@chartermedical.ie

www.chartermedical.ie

