



GP Referral for Admission to St. Patrick's University Hospital

Please complete in full and return to Assessment Unit by fax at 01- 2493609

For further enquiries please contact 01-2493635/01-2493640

For further information visit: www.stpatrickshosp.ie

Patient's Contact Details:	Referrer Details
Name:	Name:
Address:	Address
DATE OF BIRTH:	FAX NO:
PHONE NO:	PHONE NO:
GENDER: Male [] Female []	EMAIL:
INSURANCE COVER	YES <input type="checkbox"/> NO <input type="checkbox"/>
HEALTH INSURER (Please tick appropriate box)	VHI <input type="checkbox"/> QUINN <input type="checkbox"/> AVIVA <input type="checkbox"/> OTHER <input type="checkbox"/>
INSURANCE POLICY NUMBER:	

REASON FOR REFERRAL
DATE OF ONSET OF PRESENT COMPLAINT:
HAS THE PERSON SEEN YOU OR ANOTHER CLINICIAN IN RELATION TO THIS OR ANOTHER MENTAL HEALTH CONDITION PREVIOUSLY? YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
RISK TO SELF (including risk of self neglect)
RISK TO OTHERS
PAST PSYCHIATRIC HISTORY (N.B. Please include copies of correspondence)



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