



**Patient Details**

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_ Previous Name: \_\_\_\_\_

PCN/Hospital Number \_\_\_\_\_ Patient PPSN \_\_\_\_\_

Medical Card Number \_\_\_\_\_

Name of Patients G.P. \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Tel No: \_\_\_\_\_

Mobile Phone No: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Interpreter required: (For non-English speaking patients) Yes  No   
Language (Please Specify) \_\_\_\_\_

**Clinical Priority**

**G.P. Priority**

Urgent

Soon

Routine

Referred by: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of GP) GP Practice Stamp

**Consultant Priority**

Urgent: Specify clinic date or  
timeframe \_\_\_\_\_

Colonoscopy Referrals:  
 Priority 1 (Urgent)

Soon: \_\_\_\_\_

Priority 2

Routine: (Seen on priority /  
chronological order basis) \_\_\_\_\_

**For Office Use Only**

Date Received in Central Appts: \_\_\_\_\_

Date Returned from Consultant: \_\_\_\_\_

**Nature of Request**

Antenatal	
Antenatal – Midwives Clinic	
Dermatology	
ENT	
Gynaecology	
Haematology	
Immunology	
Medicine General	
Medicine Cardiology	
Medicine Respiratory	
Medicine Gastroenterology	
Medicine Geriatric Medicine	
Medicine Endocrinology	
Medicine Oncology	
Nephrology	
Neurology	
Ophthalmic	
Orthopaedic General	
Orthopaedic Hand/Limbs	
Orthopaedic Paediatric	
Orthopaedic-Trauma	
Paediatrics	
Paediatric - Community Child Health	
Pain Control	
Radiotherapy	
Rheumatology	
Surgical	
Surgical Urology	
Surgical Gastrointestinal	
Surgical Breast Clinic	
Other	

Previous Consultant: \_\_\_\_\_

**Specify Consultant if relevant:**

\_\_\_\_\_

**Recent Investigations**

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**Drug Treatments**

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**Allergies**

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**Presenting Condition**

In respect of Colonoscopy referrals please include details as appropriate re: abdominal / rectal mass, iron deficiency anaemia, rectal bleeding > 6 weeks, altered bowel habit (loose stools or diarrhoea) > 6 weeks, other indication

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**Medical History**

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**Relevant Social History**

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