Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Diabetes (Type 2) Registration Form

DOCTOR DETAILS

Doctor Number:*

Doctors Signature:*

Doctor Name, Address and Stamp:*

PATIENT DETAILS

Medical Card Number:*

Name:* _____

Address:* _____

_____

_____

Date of Birth:*

D	D	M	M	Y	Y	Y	Y

Date of Registration:*

D	D	M	M	Y	Y	Y	Y

Date of Diagnosis (if within last 5 years)

D	D	M	M	Y	Y	Y	Y

This patient has been diagnosed with type 2 Diabetes* ☐

The Practice Register has been completed with the following information:

patient's name, contact details, date of birth, gender, GMS Number and clinical measures for diagnosis* ☐

* Mandatory Fields

For further information please refer to circular S0087-NCO-15