Medical Information

To be completed by the medical practitioner/specialist/consultant/therapist, in absence of referral/motivation letter.

Contact details

Name of referring Medical practitioner _____ Telephone Number: _____

Qualification: _____ Fax number: _____

E-mail _____

Referrals

A) **Was the patient referred to you?** Yes ☐ No ☐

Name of referring Practitioner: _____ Qualification: _____

Telephone number: _____ Fax Number: _____

E-mail: _____

B) **Are you referring the patient?** Yes ☐ No ☐

Name of specialist to whom you referred the patient _____

Qualification: _____ Telephone number: _____

Symptoms

Has the patient suffered from same or similar symptoms before? Yes ☐ No ☐

If yes :-

a) On what date did Patient first notice these symptoms? _____ (dd/mm/ccyy)

b) On what date did patient first present with these symptoms to you? _____ (dd/mm/ccyy)

c) Please give details of symptoms needing treatment: _____

Details of Investigations required/requested: _____

In your opinion is this condition: ☐ Acute ☐ Chronic ☐ Acute episode of chronic condition

Has the patient been admitted to hospital for this condition? Yes ☐ No ☐

If yes :-

Admission date: _____ Discharge date: _____

In your opinion , is treatment for cosmetic reasons Yes ☐ No ☐

I declare that to the best of my knowledge and belief the statements made on this form are full, true and complete.

Medical practitioner/specialist/consultant/therapist's signature: _____

Date(dd/mm/ccyy) _____