# Highfield Healthcare

## G.P. Referral request to
## Highfield Healthcare & Hampstead Clinic Services

*Please complete in full and return to:*
Highfield Healthcare, Swords Road, Whitehall, Dublin 9.
Tel: 01-8374444 Fax: 01-8865451

Please state Referral required for –
Outpatient Appointment ☐ Inpatient Unit ☐ Day Hospital ☐

| **Patient Name:** | **Referrers Name:** |
|---|---|
| **Patient Address:** | **Referrers Address:** |
| **Date of Birth.:** | **Referrers Telephone Number(s):** |
| **Telephone Number(s):** | **Referrers Fax Number:** |
| **Gender:** | **Referrers E-Mail Address:** |

| ***Insurance Provider:** | *** Policy Number:** |
|---|---|
| | |

***Must be provided**

BLOOD RESULTS REQUIRED FOR DAY OF ASSESSMENT:
(only required for admission to Day Hospital)

FBC TFTs: Renal & LFTs:

**Reason for Referral**:

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Highfield Healthcare

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**Risk to Self:**

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**Risk to Others:**

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**Past Medical History:**

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**Past Psychiatric History:**

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**Relevant Medical and Surgical History:**

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**Family/Social History:**

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**Medications:**

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**History of Addiction or Forensics:**

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**Additional Information**

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I understand that I retain clinical responsibility for this patient until they are seen at Hampstead Clinic. Both Referrer and Patient will receive confirmation of appointment.

Signed:

________________________________________ ________________

**GP** **MCN:** **Date**