**ExWell Centre Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please send the completed form through either of the following;**

1. **Healthlink**
2. **Healthmail -** **exwellmedical@healthmail.ie**
3. **referrals@exwell.ie**
4. **Via post/delivery to – IWA, Blackheath Drive, Clontarf, Dublin 3. D03AW62**

**The ExWell Medical team will then contact the patient to arrange an induction/assessment session which usually occurs within 4 weeks of receiving a referral. Please use block capitals and ensure ALL fields are completed.**

|  |
| --- |
| **PATIENT DETAILS** |
| **FULL NAME** |  |
| **EMAIL:** |  |
| **EMERGENCY CONTACT** | **Name: Number:**  |
| **ADDRESS:**  |  |
| **DATE OF BIRTH:** | **Mob:** | **Landline:** |
| **MEDICAL CARER DETAILS** |
| **REFERRING HEALTH PROFESSIONAL NAME** |  |
| **HOSPITAL / CLINIC**  |  |
| **CONTACT** | **Tel:** | **email:** |
| **GP NAME (IF DIFFERENT TO ABOVE)** |  |
| **ADDRESS** |  |
| **CONTACTS** | **Tel:** | **Healthmail/email:** |
| **MEDICAL DETAILS** |
| **MAIN CHRONIC ILLNESS DIAGNOSIS** |  |
| **STAGING (IF CANCER)** |  |
| **CO-MORBIDITIES** |  |
| **MEDICATIONS** |  |
| **COMMENTS** |  |

 **SIGNED (Referring Health Professional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_ /\_\_\_**