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

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

1. **Healthlink**
2. **Healthmail -** [**exwellmedical@healthmail.ie**](mailto:exwellmedical@healthmail.ie)
3. [**referrals@exwell.ie**](mailto: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: \_\_\_ /\_\_\_**