**Please e-mail completed form to** **exwellmedical@healthmail.ie**

**The ExWell Medical team will then contact the patient to arrange an induction/assessment session.**

|  |
| --- |
| **PATIENT DETAILS** |
| NAME |  |
| LAST 4 DIGITS OF PPSN: |  |
| **Patient or family email address:** |  |
| ADDRESS |  |
| DATE OF BIRTH: | Mob: | Land: |
| **MEDICAL CARER DETAILS** |
| **CONSULTANT NAME** |  |
| HOSPITAL / CLINIC  |  |
| CONTACTS | Tel: | email: |
|  |
| **GP NAME** |  |
| ADDRESS |  |
| CONTACTS | Tel: | Healthmail/email: |
| **MEDICAL DETAILS** |
| MAIN DIAGNOSIS |  |
| STAGING (IF CANCER) |  |
| CO-MORBIDITIES |  |  |
| MEDICATIONS |  |  |
| COMMENTS |  |

**SIGNED: DATE:**

**Contact Tel: Contact Email:**