



Section 6: Medical History - for completion by the Admitting Consultant (Please place 'X' in required boxes)

6.1 Patient's Name: _____ 6.2 Are you the admitting consultant? Yes No

6.3 By whom was the patient referred to you? _____

6.4 Nature of symptoms/signs: _____

6.5 Duration of symptoms/signs:

HOURS		DAYS		WEEKS		MONTHS		YEARS	
H	H	D	D	W	W	M	M	Y	Y

 6.6 Date patient first consulted you with symptoms/signs:

D	D	M	M	Y	Y
---	---	---	---	---	---

6.7 Was admission: Planned Emergency 6.8 Has the patient had a previous admission for this condition? Yes No

6.9 Has the patient a history of this condition? Yes No 6.10 If Yes, please give date and details: Date:

D	D	M	M	Y	Y
---	---	---	---	---	---

Details: _____

6.11 Is the admission/treatment related to a Clinical Research Study? Yes No

Section 7: Medical Investigations - for completion by the Admitting Consultant (Please place 'X' in required boxes)

7.1 Laboratory Investigations

Biochemistry Histopathology Microbiology Immunology Haematology Endocrinology Other

Summary of key diagnostic tests performed:

7.2 If any laboratory tests were performed at another facility, please state tests and facility: _____

7.3 Radiology Investigations

X-Rays Ultrasounds CT Scans MRI's PET-CT's Others

Summary of key diagnostic tests performed:

7.4 If any radiology investigations were performed at another facility, please state tests and facility: _____

7.5 Please give Clinical Indication Description for MRI/PET-CT Scan: _____ Date:

D	D	M	M	Y	Y
---	---	---	---	---	---

D	D	M	M	Y	Y
---	---	---	---	---	---

7.6 If the MRI/PET-CT was performed at another facility, please state the facility: _____

Section 8: Diagnosis - for completion by the Admitting Consultant (Please place 'X' in required boxes)

8.1 Please list primary, secondary and other diagnosis, indicating whether acute, sub acute or chronic:

Primary Diagnosis: _____

Secondary/Other Diagnosis: _____

8.2 Does this illness contain any addictive elements (alcohol, drug or other substance abuse)? Yes No

8.3 If Yes, and if not full stay, please indicate dates of treatment relating to addictive illness:

START DATE						END DATE					
D	D	M	M	Y	Y	D	D	M	M	Y	Y

SEPTEMBER 07
HDCF2