

MEDICAL INFORMATION REQUIRED

AMI 1A

Application Number:

PPSN:

The steps are:

1. Please bring this form to your GP and request completion.
2. Your GP will return the completed report to:
Dr. J. Joyce Cooney, Client Registration Unit, PO BOX 11745, Dublin 11
3. Completed forms will be considered by HSE Community Medical Officers who, on review, may contact you directly to clarify the medical evidence.

Patients Name (BLOCK CAPITALS):

Address (BLOCK CAPITALS):

Date of birth: PPS Number: Medical Card Number:

Diagnosis (and approximate date of diagnosis) :

Medication: Important: please list all of the drugs, medicines, consumable medical and surgical appliances that are prescribed for this patient.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

How often has this client attended you in the past 12 months?:

Current Frequency of GP Visits: please tick the appropriate frequency

Weekly Monthly Other (please specify)

Observations and other relevant information:

(Additional details can be provided on the back of this form, if required)

GP Signature:

Please place official GMS stamp here

GMS Registered Number:

Medical Council Number:

Date:

