Prison Officers' Medical Aid Society

397e North Circular Road, Dublin 7. Phone: (01) 830 8963 Fax: (01) 806 2842

www.pomas.ie

FOR SUBMISSION WITH HOSPITAL CLAIM FORM

To Be Completed By Admitting Consultant

PATIENT NAME: _____ **DATE OF BIRTH:** _____

NATURE OF SYMPTOMS:

_____

_____

HOW LONG HAVE SYMPTOMS BEEN PRESENT?

_____

HAS PATIENT A HISTORY OF THIS CONDITION? YES ☐ NO ☐

If Yes, Please Give Details:

_____

_____

PROCEDURE(S) PERFORMED:

_____

_____

_____

I CERTIFY THAT THE TREATMENT OUTLINED ABOVE WAS NECESSARY:

CONSULTANT SIGNATURE: _____

DATE: _____