

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:	
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HOW LONG HAVE SYMPTOMS BEEN PRESENT?	
HAS PATIENT A HISTORY OF THIS CONDITION?	YES NO
If Yes, Please Give Details:	
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PROCEDURE(S) PERFORMED:	
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I CERTIFY THAT THE TREATMENT OUTLINED ABOVE WAS N	ECESSARY:
CONSULTANT SIGNATURE:	
DATE:	