



Referral Form – Pre-employment Medical Examination

Company Name: _____

Company Address: _____

Contact Name: _____ Tel No: _____

Contact email: _____ Date of referral: _____

PO Number: _____

Employee Details:

First Name: _____ Surname: _____ DOB: _____

Address: _____

Tel No: _____

Proposed Role: _____

Please advise the employee to bring relevant clinical/scan reports, if any, to the consultation.

Contact/Address for Invoice: _____

Please send the completed form to info@ohmi.ie