Cambridge Lea Hospital

Cambridge Oral and Maxillofacial Clinic
Private referral form

		Date of referral:

Patient details

Patient name:		**Date of birth:**
Address and postcode:		
Contact Telephone:	**Home:** **Work:** **Mobile:**	
Email address:		**Is the patient insured?** Yes ☐ No ☐
		Insurance company if known:

Referring Clinician details

Clinician name: **Address:** **Telephone:** **Fax:** **Email:**	

Referral details to be completed by Clinician:

Clinical details *Please send relevant imaging if available*	**On receipt of this referral we will contact your patient to arrange the appointment directly** **Consultant referring to:** Mr David Adlam ☐ Mr Malcolm Cameron ☐ Earliest appointment available ☐ **Date of appointment offered:** **Name of consultant:**

30 New Road
Impington
Cambridge
CB24 9EL
Main hospital switchboard: 01223 266 900

Please fax this form to Spire Cambridge Lea Hospital on **0800 587 4126** or return in the post.
Spire Cambridge Lea Hospital can provide you with pre-paid envelopes, please contact 01223 266933 if you would like us to supply. If you have any queries please call the out-patient bookings office on **01223 266 990**