

ADULT GENERAL REFERRAL FORM

Referring to: (speciality)		Hospital:	
Date of referral:			
PATIENT DETAILS			
NHS No:		Gender:	
Surname:		Forename:	Title:
Previous surname:		Date of Birth:	Age:
Address:		Home Tel. No:	
		Mobile/Day Tel No:	
		Overseas or Temporary visitor: Y/N	
PRACTICE DETAILS			
Practice Address:		National GP Code:	
		Referring GP:	
		Practice code:	
		Tel No:	
		Fax No:	
Interpreter required? Y/N		Any disability? Y/N	
If yes, please specify which language:		If yes, please specify:	
Ethnic group:		Is transport clinically necessary? Y/N	
Religion:		(All requests for transport will be reassessed at the point of booking according to DoH criteria and may be declined)	
REFERRAL INFORMATION			
Diagnosis/Reason for Referral: (Please include current symptoms, relevant history and details of any diagnostic tests)			
Medication:		Allergies:	

To submit this referral form please fax back to the relevant Spire hospital