# GP Referral Form

**Routine** ☐ **Urgent** ☐

**Appointments: 020 8971 8026** **email: appointments@parkside-hospital.co.uk**

| | | | |
|---|---|---|---|
| **Today's date:** | | | |
| **PATIENT PERSONAL DETAILS** | | | |
| NHS number | | Hospital No. | |
| Title | Surname | | Forenames(s) |
| D.O.B | Male | | Female |
| Address | | | |
| Postcode | | | |
| Telephone (Home) | | Telephone (Work) | |
| Telephone (Mobile) | | *Please give at least one contact number – mobile preferable* | |
| Email Address: | | | |
| Details of next of kin (*if referring a patient under 18 years) | | | |
| Special/Mobility needs | | | |
| **Reason For Referral** | | | |

| *REFERRING GP | PREFERRED CLINICIAN | |
|---|---|---|
| *Practice name | Name | |
| Address | Speciality | |
| *Postcode | | |
| *Telephone | | |
| *Email | | |

**CLINICAL DETAILS**

Details of any tests requested/awaited/enclosed with the referral e.g. bloods etc.

Medication/Allergies

***FOR OFFICE USE ONLY***

| | Date Patient contacted | | Appointment Date |
|---|---|---|---|