MOBILE PATIENT REFERRAL FORM

***Compulsory Information Fields. Failure to complete these fields will result in a delay of booking a patient appointment.**

PATIENT DETAILS

*Full Name: .....

*Address: .....

.....

.....

*Post code: .....

*Date of Birth: dd/mm/yyyy

*Gender ☐ Male ☐ Female

*Telephone: ..... (Home)

..... (Work)

..... (Mobile)

*Email: .....

*GP Name: .....

REFERRING CONSULTANT

*Name: .....

*Address for films and reports:

.....

.....

.....

*Postcode:

*Telephone contact: .....

*Fax: .....

*Email contact: .....

.....

*Signature: .....

*Date: dd/mm/yyyy

*Bleep/extension no.: .....

Category: NHS ☐ Ward ☐ Private ☐

Inpatients: Ward: ..... Hospital: .....

***Is there any possibility of the Patient being pregnant:** **Yes** ☐ **No** ☐

*Breastfeeding Yes ☐ No ☐ *Date of last menstrual period: dd/mm/yyyy

PAYMENT DETAILS

Insurance company name: .....

Policy/membership number: .....

Authorisation number: .....

Self pay: Yes ☐ No ☐

Private: Yes ☐ No ☐

EXAMINATION REQUESTED

Urgent ☐ Routine ☐

Area(s) to be examined/scanned: .....

Clinical details: .....

.....

.....

.....

.....

Previous surgery (please specify): .....

Previous imaging (please specify): .....

WHEN COMPLETE PLEASE SEND TO:

IHMI Patient Referral Centre | Beechwood Hall | Kingsmead Road | High Wycombe | Buckinghamshire HP11 1JL
Tel: 0845 600 2953 | Fax: 0845 600 2954 | Email: inl.petctsouth@nhs.net