Hospital for Tropical Diseases Outpatients Referral Form

To make a referral, send this form to:
Referrals Contact Centre, 250 Euston Road,
Ground Floor North, London NW1 2BU
Fax Number: 020 3447 9354

Please note that if any * starred items are not completed the referral cannot be accepted and will be returned or withheld until the completed information is obtained.

*Speciality:	Consultant (if known):
PATIENT PERSONAL DETAILS	
*Referral date: *NHS number:	*or n/k
Title: *Surname:	*Forenames(s):
*D.O.B: *Male:	*Female: Marital status:
*Address:	
*Postcode:	
*Does the patient have a telephone? Yes	No
*If yes, Home:	Work:
Mobile:	State preferred number:
Religion:	Allergies:
Overseas status *Yes* *No* *N/k*	UCLH number:
Can the patient accept short notice bookings?	*Yes* *No*
Interpreter required? *Yes* *No*	*If yes, which language?*
Special/Mobility needs:	
Details of next of kin:	
GP/GDP DETAILS	
*REFERRING GP / GDP	*REGISTERED GP PRACTICE (if different)
*Practitioner name:	*Practice name:
*Practice name:	*Address:
*Address:	
*Postcode:	*Postcode:
*Telephone:	*Telephone:
*Fax:	*Fax:
CLINICAL DETAILS	

*Comprehensive clinical details and reasons for referral:
*Details of any tests requested or awaited:
Medication:
FOR OFFICE USE ONLY
Date all correct information received