

The 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	<i>If yes, which language?</i>
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