# Patient Referral Form

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HIGHGATE
PRIVATE HOSPITAL

Outpatient Appointment ☐ Physiotherapy ☐ Diagnostic Imaging ☐ Blood Test ☐

Please Specify: _____ Details: _____

## PATIENT DETAILS

*Mandatory field

Name:* _____

Dateofbirth:* _____

Hospital Number: _____

Address:* _____

_____

_____

Postcode:* _____

Phone:* _____

Email:* _____

Male ☐ Female ☐

Start date of last menstrual period *(if applicable)*:

_____

Patient Arrival: Trolley ☐ Wheelchair ☐ Walking ☐

Funding: NHS ☐ Self Funded ☐ Insured ☐

Patients insurance company:* _____

Membership number: _____

Pre-authorisation number *(if known)*: _____

***Please note: Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment.***

Date of Birth:____ /____ /____ LMP: ____ /____ /____

Male ☐ Female ☐

Insured ☐ with _____ Self-Pay ☐

Membership No: _____

Tel: _____

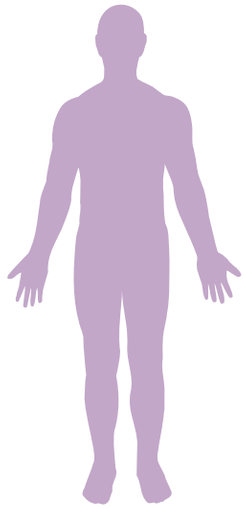
Fax: _____

Email: _____

Signature: _____

Name of Consultant or speciality you are referring to: Date:

Clinical information:*



Remarks / Comments:

**FOR HOSPITAL USE ONLY**

Notes:

Date Received: _____