GP Referral Form	
Referral Details	
Practice Name	
Specialty / Service required	
Has the Patient previously been referred to NHS for a hair system	□ Yes □ No
Priority (GP)	□ Urgent □ Routine
Date of referral	
Patient Details	
Surname	
First Name	
Address	
Date of Birth	
Gender	
Next of Kin	
Mobile Number	
Telephone (day)	
Telephone (evening)	
Hospital Number	
First Language	
Interpreter required	□ Yes □ No
Wheelchair Assistance	□ Yes □ No
Referrer details	
Name	
Address	
Telephone	
Fax	
Mobile	
Signature of Referrer	
Medical Council Registration Number	

Clinical information
Reason for referral / Anticipated outcome:
Symptoms (including history of presenting complaints and interventions to date):
Examination findings:
Relevant tests / investigations: □ Attached □ Not applicable
Past Medical history:
Current medication:
Allergies / Adverse medication events:
Relevant Family History:
Additional Relevant information (including special needs, disabilities, clinical warnings):