|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Details** (to be fully completed by the patient or guardian) | | | |
| **Date** | |  | |
| **Patient Name** | |  | |
| **Patient Sport** | |  | |
| **Patient Date of Birth** | |  | |
| **Patient Address** | |  | |
| **Postcode:** | |
| **Patient Contact Numbers**  Can voicemails be left? | | **Home:**  **Mobile:**  **Work:**  **Yes No** | |
| **Patient E-mail Address**  *Appointment letters will be sent via e-mail* | |  | |
| **Third Party Consent**  *If the patient consents to Priory to speak with a third party, please provide their details* | | **Name:**  **Contact Number:**  **Relationship to patient:** | |
| **GP Information**  ***Patient consent must be granted to contact GP****. Referrals that do not provide consent or those submitted without GP information (name, address and contact number) will be declined by Priory.* | | **GP Name:**  **Surgery Address**:  **Phone Number:** | |
| **Funding**  Please advise if the treatment will be self funded or paid by Private Medical Insurance (PMI) | | **Self Funded PMI Funded**  If PMI funded, please confirm:  PMI Provider:  Membership Number:  Authorisation Number:  Excess Payment Amount: £ | |
| **Consent**  If your treatment will be funded by PMI, please confirm that Priory may share relevant clinical information with your PMI to secure funding | | **Yes No** | |
| Brief reason for referral | |  | |
| **Patient Availability**  (to be fully completed by the patient or guardian) | | | |
| **Please provide availability for the first appointment.** *Sites will offer appointments based on your availability.*  Notes on availability: | | |  |  |  |  | | --- | --- | --- | --- | |  | Morning | Afternoon | Evening | | Monday |  |  |  | | Tuesday |  |  |  | | Wednesday |  |  |  | | Thursday |  |  |  | | Friday |  |  |  | | Saturday |  |  |  | | |
| **Authorisation** | | | |
| I confirm I am the patient or legal guardian of the patient: Yes No | | | |
|  |  | |  |
| Name | Signature | | Date |