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| **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: |

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| --- | --- | --- | --- |
|  | Morning | Afternoon | Evening |
| Monday |[ ] [ ] [ ]
| Tuesday |[ ] [ ] [ ]
| Wednesday |[ ] [ ] [ ]
| Thursday |[ ] [ ] [ ]
| Friday |[ ] [ ] [ ]
| Saturday |[ ] [ ] [ ]

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| **Authorisation**   |
| I confirm I am the patient or legal guardian of the patient: [ ] Yes [ ] No |
|  |  |  |
| Name | Signature | Date |