GP and AHP Referral Form

OSD Healthcare

Please complete all known details and return to OSD Healthcare via:

Post: FAO GP Engagement Manager, OSD Healthcare, One Medical House, Boundary Way, Hemel Hempstead, HP2 7YU

Email: referrals@osdhealthcare.co.uk

Patient details

Surname: ..... Gender: .....

Forename: ..... DOB (dd/mm/yy) .....

Address: .....

..... Postcode: .....

Home Tel: ..... Work Tel: .....

Mobile Tel: ..... Email Address: .....

Is the patient: Insured ☐ Self-pay ☐

Insurer's Name: ..... Membership Number: .....

Practitioner's details

Name: .....

Practice Address: .....

.....

.....

Postcode: .....

Telephone: .....

Email Address: .....

For address stamp

Referral details

Speciality: .....

Preferred consultant(s): .....

Reason for referral (current symptoms, relevant history, known triggers, precipitating factors, protective factors, dual diagnosis)

Preferred time frame for appointment:	Urgent ☐ Non-Urgent ☐
Other (please specify):	
Patient medication:	
Allergies and medical history:	
Investigations:	
Recent consultations	

Additional supporting information **(Please attach any recent tests/results)**

Referring clinician:

Signature: ..... Date: .....

Print Name: .....

OFFICIAL USE ONLY
Date patient contacted: ..... Appointment date: .....