GP and AHP Referral Form

one Hatfield Hospital

Please complete with all known details.

Post to: Reservations, One Hatfield Hospital, Hatfield Avenue, Hatfield Business Park, Hatfield AL10 9UA

Email to: one.hatfield@nhs.net

01707 44 33 33
onehatfieldhospital.co.uk

Patient's details

Surname		Gender: Male ☐ Female ☐	
Forename		Date of birth	
Address			
		Postcode	
Telephone (home)		Telephone (work)	
Telephone (mobile)		Is the patient: Insured ☐ Self-pay ☐	
Insurer's name		Membership number	

Practitioner's details

Name		For address stamp
Address		
Postcode		
Telephone		

Referral details

Speciality	
Preferred consultant(s)	
Reason for referral	
Preferred time/date for appointment: Urgent ☐ One week's time ☐ Within one month ☐	
Other (please specify)	

Referring clinician

Signature		Date	