

# GP and AHP Referral Form

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 <input type="checkbox"/>	Female <input type="checkbox"/>
Forename		Date of birth	
Address			
	Postcode		
Telephone (home)		Telephone (work)	
Telephone (mobile)		Is the patient: Insured <input type="checkbox"/>	Self-pay <input type="checkbox"/>
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 <input type="checkbox"/>	One week's time <input type="checkbox"/>	Within one month <input type="checkbox"/>
Other (please specify)			

## Referring clinician

Signature		Date	
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