gesh

NHS
St George's University Hospitals
NHS Foundation Trust

ADULT HAND THERAPY REFERRAL

INCOMPLETE REFERRALS WILL BE RETURNED TO REFERRER – please provide additional information separately if required

Therapies Booking Hub Tel: 0208 725 0007. Email form to: therapiesbookinghub@stgeorges.nhs.uk

<table>
<tr><td colspan="2">PATIENTS DETAILS</td><td colspan="3"></td></tr>
<tr><td colspan="5">NHS NUMBER:</td></tr>
<tr><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="2">PATIENT'S NAME: (IN CAPITALS)</td><td>GP NAME: (PRINT)</td><td colspan="2"></td></tr>
<tr><td colspan="2"></td><td>SURGERY ADDRESS: (PRINT)</td><td colspan="2"></td></tr>
<tr><td colspan="2">PATIENT'S FULL ADDRESS: Complete in all cases</td><td>DOB:</td><td colspan="2">SEX:</td></tr>
<tr><td colspan="2" rowspan="4">POSTCODE:</td><td></td><td>Male ☐</td><td>Female ☐</td></tr>
<tr><td>Must be 16 or over</td><td colspan="2" rowspan="3"></td></tr>
<tr><td>Home Tel:</td></tr>
<tr><td>Mobile:</td></tr>
<tr><td>INTERPRETER REQUIRED? If yes, which Language?</td><td>Yes ☐ No ☐</td><td>CONSENT TO LEAVE TELEPHONE MESSAGE?</td><td colspan="2">Yes ☐ No ☐</td></tr>
<tr><td>OCCUPATION:</td><td></td><td>OFF WORK DUE TO THE PROBLEM?</td><td colspan="2">Yes ☐ No ☐</td></tr>
<tr><td>DISTURBED SLEEP DUE TO THIS PROBLEM?</td><td>Yes ☐ No ☐</td><td>FLARE UP OF CHRONIC CONDITION?</td><td colspan="2">Yes ☐ No ☐</td></tr>
<tr><td>TIME SINCE ONSET:</td><td colspan="4">WEEKS / YEARS</td></tr>
<tr><td colspan="2">DIAGNOSIS AND/OR OPERATION DATE & DETAILS:</td><td colspan="3">SCAN / X-RAY FINDINGS:</td></tr>
<tr><td colspan="2">REASON FOR REFERRAL:</td><td colspan="3">OTHER RELEVANT INFORMATION:</td></tr>
<tr><td colspan="3">REFERRING CLINICIAN/DESIGNATION:

REFERRER EMAIL/CONTACT NUMBER:</td><td colspan="2">DATE:</td></tr>
</table>