GP Liaison Referral Form

Please complete with all known details
and **fax** this form back to **020 7234 2019**

GP Liaison – **Tel: 020 7234 2009**
GPliaisonlbh@hcahealthcare.co.uk

London Bridge Hospital

27-29 Tooley Street,
London SE1 2PR

Tel: 020 7407 3100
Fax: 020 7407 3162
Web: www.londonbridgehospital.com

Patient Details

Surname: _____ Gender: Male ☐ Female ☐

Forename: _____ Date of Birth: _____

Address: _____

_____ Postcode: _____

Tel No Home: _____ Work: _____

Is the patient: Insured ☐ Self Pay ☐ (please tick) Mobile: _____

Insurance Details

Medical Insurer's Name: _____

Membership No: _____

Practitioner's Details

Practitioner's Name: _____

Practitioner's Address: _____

_____

_____

_____ Postcode: _____

Tel No: _____

For address stamp

Referral Details

Specialty: _____

Preferred Consultant(s) (if known): _____

Reason for Referral: _____

_____

_____

_____

Preferred time/date for appointment:

Urgent ☐ One week's time ☐ Within one month ☐ Other (please specify) _____

Referring Clinician's
Signature: Date: