Guy's and St Thomas'
Private Healthcare

GP Referral Form

Patient details

Surname: _____ Gender: Male ☐ Female ☐

Forename: _____ Date of birth: _____

Address: _____

_____ Postcode: _____

Telephone: _____ Work: _____

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

Medical insurer: _____ Membership no: _____

GP details

GP name: _____

GP practice: _____

_____

_____

_____ Postcode: _____

Telephone: _____

For address stamp

Email: _____ GP no: _____ Practice no: _____

Referral details

Speciality: _____

Preferred consultant(s) (if known): _____

Reason for referral: _____

_____

_____

_____

Preferred date for appointment:

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

Referring GP/clinician's signature:

Date:

Please complete the form and return by fax to **020 7188 5203** or email to **privateinpatients@gstt.nhs.uk**

November 2018