Occupational therapy service

Outpatients / Hand therapy referral only

Please complete all fields

Mr / Mrs / Miss/ Ms / Dr / Surname……..

Forename: ……..…… Preferred name: ……..……

Address (or affix sticker): ……..……

……

…… Postcode: ……..……...

Tel No: (h)…….. GP name/address: ……..…….

(w)…….. ……..……..

(m)…….. ……..……..……

Date of birth: …… NHS No: ……..……..……

Consultant: ……..…….... Date of injury: ……

Date of surgery: …….

Diagnosis: …..……

……

Treatment required: ……

……..…..

Clinical protocol to be followed: ……

……..

Name of referrer: …..……

Team: ..……....

Signature: …… Contact number: ……..……

Date of referral: …….. Date of discharge: ……..……

Please return this form to: Occupational hand therapy service, Admin office level 3, St. Bartholomew's Hospital, New Road, Rochester, Kent, ME1 1DS

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