



Mansion House, 3 Bridgewater Embankment, Altrincham, Cheshire, WA14 4RW  
Tel: 0161 929 5679 Fax: 0161 941 6486

**Referral Letter:** Please complete and return by fax to **0161 941 6486** or by email to **info@dhc.uk.com**

**Patient Details:**

**Surname:** \_\_\_\_\_ **Forename:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Postcode:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Mobile Number:** \_\_\_\_\_

**Funding:** NHS / Self Funded / Private Patient / Other: \_\_\_\_\_

**Referrer Details:**

**Company/Hospital:** \_\_\_\_\_

**Consultants Name:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Postcode:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**GP's Name & Address:** \_\_\_\_\_

**Patient's Insurance Company:** \_\_\_\_\_ **Membership No:** \_\_\_\_\_

**Insurance Authorisation No:** \_\_\_\_\_

**Required Examination:**

- |   |  |
|---|--|
| <input type="checkbox"/> Exercise ECG     | <input type="checkbox"/> MRI _____         |
| <input type="checkbox"/> Bone Density     | <input type="checkbox"/> Ultrasound _____  |
| <input type="checkbox"/> Health Screening | <input type="checkbox"/> Blood test: _____ |
| <input type="checkbox"/> X-ray: _____     | <input type="checkbox"/> Other: _____      |

**Reason for referral:**

\_\_\_\_\_

\_\_\_\_\_

**Referrers Name:** \_\_\_\_\_

**Referrer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Many Thanks for your Referral.**