

Medefer Referral Form

Referral criteria:

- For non-paediatric specialties: all adult medical referrals excluding 2WW or Urgent
- Paediatrics: all referrals except 2WW or Urgent

Please ensure this form is fully completed and attach any relevant additional information and send the referrals to referrals.medefer@nhs.net.

NHS Number:	807 269 7404
Title:	Mr
First name:	Zion
Surname:	Merge
Address:	24 Western Rd, Romford RM1 3JT
Telephone:	073 456 45158
Gender:	male
DOB:	08/05/1962
Ethnicity:	British
Email:	12345@gmail.com

Please fill in this section

Specialty:	Gastroenterology
Sub-Specialty:	
Patient's consent gained for referring to Medefer:	Yes
In case an outpatient referral is required, which hospital would the patient like to be seen at?	Not Applicable (advice only requested)
Without access to Medefer services, would you have referred this patient to the hospital for review?	Yes
Is the patient happy to be contacted for feedback?	Either
Is this a new or follow-up referral:	No
Follow up reference number: (This is located on the Medefer Consultant Response letter)	
Clinical Query by the GP: (Please detail your clinical query for the Consultant)	Lets see this again Doing this INSIDE YOU Help him Test

Medefer Referral Form

GP name:	Westbury Medical Centre
Practice Name:	Westbury Medical Centre
Practice Number:	F85031
Practice email:	uatuser@medefer.com
Medical History; cardiology COME OUT	