# Nightingale Hospital

# Patient Referral Form

**Service required:**

☐ Outpatient psychiatric consultation ☐ Outpatient therapy

☐ Day therapy ☐ Inpatient admission

**Patient Name**:

**Address**:

**Patient Contact Number:** Would you like us to call your patient regarding appointments? ☐ (If yes, please provide us with a number which the patient is happy to be contacted on)

**Date of Birth:** **Payor:** ☐ Self-pay ☐ Insurer ☐ 3rd Party

**Insurance company:**

**Provisional diagnosis:**

**Relevant Information:**

**Referrer:**

**Referrer Address:**

**Referrer Tel No:**

**Referrer Email:**

**Referral Date:**

**Please fax or email your referral to 020 7724 5976 / patientservices@nightingalehospital.co.uk**
**11-19 Lisson Grove Marylebone London NW1 6SH**
**Tel: +44 (0)20 7535 7700 Fax: +44 (0)20 7724 5976 Website: www.nightingalehospital.co.uk**