CHARING MEDICAL PARTNERSHIP, 1 SURGERY CLOSE, CHARING, ASHFORD, KENT TN27 0AW. TEL: 01233 714490

UROLOGY CLINIC REFERRAL FORM

Please fax to 01233 713782 or email charingsurgery@nhs.net

Exclusions include: Cancer or suspected cancer, pure uro-gynae problems, children less than 7 years.

Pre-Referral: Please ensure your patient has had a blood test to include FBC, PSA (if they have a prostate) & eGFR and include the results with this referral form.

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1. PATIENT DETAILS

Patient Full Name: _____

Gender _____ Date of Birth: _____ NHS No: _____

Address: _____

_____

_____ Postcode _____

Home Phone: _____ Mobile _____

Tick if the patient requires Assistance ☐ Interpreter ☐ Chaperone ☐

2. CLINICAL DETAILS - Attach a referral letter or give details below of …

Clinical condition, symptoms and indications, including relevant previous medical history.

3. REFERRING PRACTICE DETAILS

Referring Doctor: _____

Surgery Address: _____

Tel No: _____

Fax No: _____

Email: _____

Referrer's Signature: _____ Date of Referral: _____