**North West Diagnostic & Treatment Services**

**Minor Surgery – Referral Form**

bringing specialist services to the heart

of your community

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| **DATE OF REFERRAL** |  | | Routine □ Urgent □ |
| **PATIENT NAME** |  | | |
| **DOB** |  | | |
| **NHS NUMBER** |  | | |
| **HOME TELEPHONE NUMBER** |  | | |
| **MOBILE TELEPHONE NUMBER** |  | | |
| **ADDRESS** |  | | |
| **CARERS CONTACT DETAILS**  **Please complete this section if applicable** |  | | |
| **MINOR SURGERY DETAILS** | **Lesion Macro** |  | |
| **Site** |  | |
| **Size** |  | |
| **Reason for Request** |  | |
| **Medication** |  | |
| **Allergies** |  | |
|  |  | | |
| **REFERRING GP** |  | | |
|  |  | | |
| **ADDRESS OF REFERRING GP/CLINICIAN** |  | | |
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| **Please e-mail to:** | Email (via NHS Mail): [northwestdiagnostics@nhs.net](mailto:northwestdiagnostics@nhs.net) |

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| **Service use only**  **MHS Triage - Book in with** | PN LD |