University Hospitals Birmingham NHS
NHS Foundation Trust

Direct access diagnostics referral form

DATE OF GP APPOINTMENT		DATE RECEIVED		APPOINTMENT DATE	

PATIENT DETAILS

Name______________________________________ Sex M/F

DOB_______________ NHS No______________________

Address ____

____

Postcode_________ Tel No_______________ **(Mandatory)**

Hospital Number____________________________________

1st Language____________________ Interpreter Req Y/N

GP

Name: ______________________________

Practice: ____________________________

Address/Stamp

Tel No: _______________ Fax: _____________

E-mail: __________________________________

Date of referral:

Direct Access Test (please tick the box next to the test that you require)

ECHO ☐ For Echo, has new onset of AF been confirmed by ECG? **YES** ☐ **NO** ☐

24 Hour ECG ☐

Routine 12 Lead ECG ☐

Results of any Primary Care Assessment

Blood Pressure

FBC

U&E

Lipids

ECG (please attach copy if available)

Current Medications

Drug Sensitivity

Information to be filled in by receiving clerical staff

Any Other Information

Please fax/email this form to the fax gateway number: 0121