

This form should be sent to our central referral office marked as URGENT to:
Sbu.referrals.wfi@wales.nhs.uk

Patient ID

Partner ID [if applicable] – if patient has a partner who is not currently registered

PATIENT CONTACT TELEPHONE NUMBER

REFERRER – Please complete all details and send with relevant referral information as indicated overleaf

Name of referring clinician	
Hospital/Referral Centre [including postcode]	
Telephone/Extension or Bleep Number [Please ensure a contact no. is added]	
Referral date	

DIAGNOSIS:

Type of Surgical Treatment	
Date of surgical treatment	

TREATMENT PLAN	YES	If Yes Date planned:	NO
CHEMOTHERAPY	YES		NO
RADIOTHERAPY	YES		NO
MEDICAL TREATMENT [ie. GnRH agonist, aromatase inhibitors]	YES		NO

INVESTIGATIONS – Please indicate and write results:

Investigation	Result
Full Blood Count	
Clotting	
U&E's	
LFT's	

INFORMATION LEAFLET PROVIDED TO PATIENT

YES / NO

PLEASE CONTINUE OVERLEAF TO PROVIDE INFORMATION IN RELATION TO THE PATIENTS CLINICAL CARE:

PATIENT HISTORY/CLINICAL CARE INFORMATION:

Please use this space to provide information relating to the patient's medical history and clinical care:

For WFI use only

Referral accepted	Expedited	Add as an urgent additional patient for clinical consultation
Referral declined	Not eligible	Not suitable
Vetting	Signature	Date