DIRECT REFERRAL FORM TEMPLATE

Information Required Before Referring Patient To Out Of Hours (OOH)

Patient's Name	
Patient's Address	
Patient's Home Phone Number	
Patient's Mobile Phone Number	
Patient's Date of Birth (DOB)	
Patient's Doctor	
Patient's Surgery	
Brief description of symptoms	
Current Location	

Information OOH will provide[1]

Time of appointment	
Location of care	

[1] Except for Greater Glasgow – refer to section 6