# GP Right to Choose Referral

**Please fill in the below information for the individual you are referring.**

## Personal details

First name

Last name

Date of birth *(dd/mm/yyyy)*

Email address

Address

Postcode

Contact number

# GP Right to Choose Referral

**Please fill in the below information for the individual you are referring.**

## GP details

As the referring GP, we need to know your full contact information, including your surgery's address, which must be the practice the person being referred is registered to.

What is the name and address of your surgery?

Please provide your GP Practice Code (e.g. A 00000)

**Please add your professional contact details below. The address must be an NHS.net address only, and a surgery email wherever possible.**

First name

Last name

Email address

Which integrated care board (ICB) is your GP surgery part of?

Which responsible borough or locality within the ICB is your surgery located in? (Write n/a if not applicable), e.g. NHS South West London ICB - Kingston Upon Thames

## Patient information

**We only offer remote assessments through Right to Choose. Please ensure the patient is aware and comfortable with this.**

What type of assessment are you referring this individual for?

- [ ] Child ADHD
- [ ] Child Autism
- [ ] Child ADHD and Autism

Please provide a brief medical summary of the patient. This should include any observations relating to the reasons for referral, and any other relevant known diagnoses.

**Please attach a summary of the patient's medical history (summary care record) and a referral letter on headed paper. These documents are required before we can accept a referral.**

What is the patients NHS number?

What is the patients preferred spoken language?

Does the patient require any reasonable adjustments?