OneWelbeck Women's Health

OneWelbeck Women's Health Patient Booking Form

Please complete all sections of the form. By completing this form, you confirm you have the consent required to share this information.

PATIENT DETAILS

TITLE:	FORENAME(S):	SURNAME:
DATE OF BIRTH:		GENDER: ☐ MALE ☐ FEMALE ☐ OTHER
RESIDENTIAL ADDRESS:		POSTCODE:
TELEPHONE:		MOBILE:
EMAIL:		

REFERRAL DETAIL

☐ Consultation with Gynaecology Consultant

Tests/Procedures

- ☐ Diagnostic Ultrasound
- ☐ Ultrasound guided biopsy(ies)/pipelle
- ☐ Ultrasound guided drainage of fluid collection
- ☐ Hysteroscopy +/- biopsy/polypectomy
- ☐ Colposcopy
- ☐ Cystoscopy
- ☐ Smear
- ☐ Coil replacement/insertion/removal
- ☐ Urodynamic testing
- ☐ HyCoSy
- ☐ Saline Sonogram
- ☐ Bladder instillation
- ☐ DEXA
- ☐ Blood Tests (please specify):

Please complete the below for procedures:

KNOWN ALLERGIES:

BLOOD THINNING MEDICATION:

INDICATION, MEDICAL HISTORY AND CLINICAL DETAILS (REQUIRED):

EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS:	WHEELCHAIR ACCESS: ☐
INTERPRETER REQUIRED: ☐ Yes, please confirm language:	
OTHER:	

REFERRER DETAILS

GP/REFERRER NAME :	GP/REFERRER PRACTICE :
GP/REFERRER CONTACT NUMBER:	GP/REFERRER EMAIL:

PAYMENT DETAILS (IF KNOWN)

☐ Bill to Patient	☐ Bill to Insurer INSURANCE COMPANY: MEMBERSHIP NO: AUTHORISATION CODE:	☐ Bill to Embassy EMBASSY: LETTER OF GUARANTEE: ☐ (Please attach)	☐ Bill to referrer AGENCY NAME:

NAME : SIGNED : DATE :

PROFESSIONAL REG NO:

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:

E: bookings.womenshealth@onewelbeck.com **A:** Bookings, OneWelbeck Women's Health, 1 Welbeck Street London W1G 0AR **T:** +44 (0)203 6532008