Therapies on Thames
Rehabilitation Specialists

THERAPIES ON THAMES - PATIENT REFERRAL FORM

PLEASE PRINT DETAILS IN BLOCK LETTERS

	Date:
PATIENT DETAILS- Mr/Mrs/Ms/Miss	
First Name: SURNAME:	D.O.B :
Address: Postcode:	
Phone :	Primary Contact: ☐ Patient ☐ NOK ☐ Other Ph :
NOK / Guardian (please circle)	Phone : Relationship :
DIAGNOSIS / REASON FOR REFERRAL:	
REFERRER DETAILS (PLEASE COMPLETE ALL DETAILS)	
Referrer :	Organisation:
Phone : Fax :	Mobile :
Address:	Email:
Why did you choose our service?	
GP DETAILS (PLEASE COMPLETE ALL DETAILS)	
Name of GP:	Practice Name :
Phone :	Practice Email-
Address: Post Code:	
THERAPY DETAILS	
Therapy to commence(date):	Discharge date : (from hospital)
Therapy Required: ☐ PT ☐ OT ☐ SALT	

Many thanks for your referral.

Please post the referral to Therapies on Thames Limited, 50 Battle Square, Reading. RG30 1AL (or) email to contact@therapiesonthames.co.uk. Tel: 020 8150 6447

Please attach any other relevant clinical information that would help with this referral.