

## Self-referral form

Please complete this form and send it to us in the addressed envelope provided.

Any forms we receive from 9.00am-5.00pm on Monday-Friday will be dealt with as soon as possible within 48 hours.

*By submitting this form, you consent to your information being shared with Insight Healthcare. This information is handled confidentially, in accordance with the Data Protection Act 2018. Visit [www.insighthealthcare.org/privacy-notice](http://www.insighthealthcare.org/privacy-notice) for more information.*

### Your details

First name:\*

Surname:\*

Gender:\* male ☐ female ☐

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

Address line 1:\*

Address line 2:

Town/city:\*

County:

Postcode:\*

Do you require an interpreter?

Yes ☐ No ☐

If so, which language?

### GP details

Your NHS number:

(this can be obtained from your GP surgery)

Name of GP:

GP surgery:\*

### Contact details

Can we contact you at your given address?\*

Yes ☐ No ☐

Email address:

.....

Can we contact you using this email address?

Yes ☐ No ☐

Telephone 1:\*

.....

Can we send you text messages on this number?

Yes ☐ No ☐

Can we leave a voicemail on this number?\*

Yes ☐ No ☐

Telephone 2:

.....

Can we send you text messages on this number?

Yes ☐ No ☐

Can we leave a voicemail on this number?

Yes ☐ No ☐

*Please note that we will usually contact you by telephone from a withheld number, unless it is made clear that you do not wish to be contacted in this way.*

\*Please note that if any fields marked with \* are not completed, we will not be able to process this referral.

**In the event of an emergency, or if you are unable to keep yourself safe, you should contact your GP, your local A&E department, or call 999.**