Barnsley Hospital
NHS Foundation Trust

BEAUTY/COMPLIMENTARY THERAPY REFERRAL FORM

TO BE COMPLETED BY THE REFERRER

Name of patient/carer **Address** **Postcode** **Date of Birth** **Unit Number** **Telephone Number (s)**	**Next of Kin and Relationship**
Inpatient	**Date of Admission:**
Outpatient	
Primary Diagnosis	**Date:**
Secondaries	**Date:**
Any other issues therapist needs to be aware of (including Mental Health/Social)	
Current medication and treatment regime	
Allergies	
Consultant and Specialty	
Reason for referral	

PRIORITY (please circle as appropriate) **LOW / MEDIUM / HIGH**

Patient history/Relevant information (INCLUDING PAST MEDICAL HISTORY)

Referred by: **Date:**

Contact Number: