|  |  |  |
| --- | --- | --- |
| **Patient details:**  ***(name, address, chi)*** |  | **GP details:** |

|  |  |
| --- | --- |
| **Medical diagnosis:**    **Age of diagnosis:**    **Have they been referred to this service before?** | |
| **Description of presenting difficulties (e.g. anxiety, low mood, adherence to treatment issues, duration of difficulties etc):** | |
| **Any other relevant information:** | |
| **Date of referral:** Click to enter a date. | **Consultant:**  **Name of referrer:**    **Other contact to discuss referral with (if any):** |

**Please email this form to** [**rie.haemophilia@nhslothian.scot.nhs.uk**](mailto:rie.haemophilia@nhslothian.scot.nhs.uk)

**Please feel free to contact us on 0131 242 1270 and we would be happy to discuss the referral with you. Please attach a recent clinic letter with more information if you feel this would also be helpful.**