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

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| **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**

**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.**