

Please complete this form and return via:

Email: referrals@jointclinics.co.uk | Fax: 0121 000 0000 | Online: JointClinics.co.uk/services/refer-patient

SECTION 1: PATIENT DETAILS

First Name *

Surname *

Date of Birth *

Contact Number *

Patient Email (optional)

Patient Address

SECTION 2: REFERRING CLINICIAN DETAILS

Professional Role *

General Practitioner (GP)

Physiotherapist

Consultant / Clinician

Your Full Name *

Your Contact Number *

Practice / Clinic Name *

Practice Address *

Your Email (optional)

SECTION 3: REFERRAL DETAILS

Affected Joint Area:

Hip

Knee

Ankle

Foot

Hand / Wrist

Elbow

Shoulder

Urgency:

Routine

Urgent

Emergency

Condition Summary / Reason for Referral *

Preferred Clinic Location:

Birmingham (Edgbaston)

Bristol (North Bristol)

Bromsgrove

Additional Notes

Our Follow-Up Guarantee

By submitting this referral, JointClinics guarantees that your patient will be booked back at your clinic for follow-up after their assessment or treatment. We will provide a comprehensive report of all findings and treatment plans.