

## INTER PROVIDER TRANSFER FORM

<b>REFERRING ORGANISATION:</b>		
Date of decision to refer:		
Organisation name:	Organisational code: (organisation receiving initial referral)	
Referring Clinician:	Referrer code:	
Referring Specialty /Function		
Contact name: (Usually consultant secretary)		
Contact telephone number:	Email address:	
<b>PATIENT DETAILS:</b>		
Patient's title / name:	DOB	
Correspondence address:	NHS Number	
	Contact details	
	• Telephone number	
	• Alternative number	
Postcode:	• Mobile	
<b>GP DETAILS:</b>		
GP Name	GP Practice Code	
<b>18 WEEK RTT STATUS</b>		
Is the patients 18 week pathway open:	YES	NO
Latest 18 week clock start date:		
Not yet treated:		
Unique pathway identifier: (patient)		
<b>RECEIVING ORGANISATION DETAILS:</b>		
Receiving Organisation Name: • <i>Dorset County Hospital Foundation Trust</i>		
Receiving Organisation Code • <i>RB DO1</i>		
Receiving Clinician:		
Receiving treatment function (specialty)		
<b>FOR RECEIVING ORGANISATION:</b>		
Date and time received:		