Patient Referral Form

Patient Information

Name of Patient: ....

Address of Patient: ....

Contact Tel No: ....

Date of Birth...

Reason for Referral

Referring Health Practitioners Information

Name of Referring Practitioner:...

Position: ....

Business Address: ....

Contact Tel No: ....

Exclusion Criteria for the 8 Week Mindfulness and Meditation Programme may include:

COPD, Severe Asthma, Epilepsy, Symptoms of PTSD, Psychosis, Active Suicidality

Please confirm that the patient you are referring does not fall into any of these categories.

Relevant Medical History:...
....
....

I confirm that this patient's physical and mental health is suitable for taking part in Mindfulness sessions.

Signature of Referring Professional: ....

Date: ....

All Information supplied will be held in accordance with our

Privacy Policy and Data Protection and GDPR Regulations.