# Inter-Provider Administrative Data Transfer (also for Internal Referrals)
## This excludes where existing Tertiary Pro-forma exists.

## Please complete all relevant fields

| | |
|---|---|
| Referring Organisation Code:  **RM100** | Referring Specialty Code: |
| Referring Clinician: | Referring Clinician GMC Code: |
| Contact Name: | Contact Tel. No: |
| | Contact e-mail: |

| **Patient Information** | |
|---|---|
| Hospital No: | NHS No: |
| Surname: | Forename(s) |
| DOB: | Title: |
| Sex:          Male ☐ Female ☐ | Lead Contact:       Patient ☐ Other ☐ |
| BMI: | If Other, Name: & Relationship: |
| Address & Postcode: | Contact Home Tel: |
| | Contact Work Tel: |
| | Contact Mobile: |
| | Contact e-mail: |

| **Registered GP Information** | |
|---|---|
| Registered GP Name: | GP Practice Code: |
| Registered GP Tel. No: | |

| **Referral Information** | |
|---|---|

**Is this patient on an 18 week pathway (on-going 18 week pathway at the point of requesting a transfer of care)?**

| **YES** | **Answer** |
|---|---|
| Latest RTT Code 21 or 20: | |
| Latest Clock start date: | |
| Date of decision to refer: | |
| Unique Pathway Identifier if appropriate: | |
| Pathway Identifier allocated by organisation: | |
| Is this referral for: A diagnostic test only? or | ☐ |
| Opinion only (with no view for treatment)? | ☐ |
| Reason for referral: | **Urgent**   ☐          **Routine**   ☐ |

| **NO** | **Answer** |
|---|---|
| Latest RTT Code 3 or 9: | |
| Date patient was treated: | |
| Date of decision to refer: | |
| Is this referral for: A diagnostic test only? or | ☐ |
| Opinion only (with no view for treatment)? | ☐ |
| Reason for referral: | |

| **Receiving Organisation details:** | |
|---|---|
| Receiving Organisation Name: | |
| Receiving Organisation Code: | |
| Receiving Clinician (optional): | |
| Receiving Specialty Code: | Date data transfer sent: |
| **For Receiving Organisation** | Date Received: |