**IDD Therapy Disc Clinics**, S2 Allen House, The Maltings,

Station Road, Sawbridgeworth, Hertfordshire, CM21 9JX

t: 0345 625 2566 e: info@iddtherapy.co.uk

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| To locate an IDD Therapy treatment provider go to: **www.iddtherapy.co.uk/clinic-finder** |

**Referral Form Date:**

|  |  |  |  |  |  |  |
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| **PATIENT** | | | |  | **IDD THERAPY PROVIDER** | |
| Name |  | | |  | Clinic |  |
| Gender |  | | |  | Town |  |
| Address |  | | |  | Tel |  |
|  |  | | |  |  |  |
| Town |  | Postcode |  |  |  |  |
| Tel |  | | |  |  |  |
| Email |  | | |  |  |  |

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| **PATHOLOGY** |
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| **PREVIOUS TREATMENTS** |
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| **MRI SCAN YES/NO?** |  | **MRI < 6 MONTHS OLD YES/ NO?** |  |

(Please attach MRI report summary if you have it)

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| **ADDITIONAL COMMENTS** |
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| **REFERRING CLINICIAN** | | | |
| Name |  | Profession |  |
| Clinic |  | | |
| Address |  | | |
| Town |  | Postcode |  |
| Phone |  | | |
| Email |  | | |
| Signature |  | | |

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| ***IDD THERAPY PROVIDER USE ONLY*** | | | |
| Received By |  | Acknowledged By |  |
| Date |  | Date |  |

*s:iddtherapy/referral form 01012016* Print forms: **www.iddtherapy.co.uk/referral**