Therapy 4 Healing

Beneficiary Referral Form

Please fill in using BLOCK CAPITALS. If you are unsure how to complete, please ask your GP to help you.

PLEASE SEND FORM BACK TO info@T4H.org.uk or T4H Head Office, 120 Stanstead Road, Forest Hill, London. SE23 1BX

Personal Details

Title:			
Name:		Surname	
Address:			
Postcode:			
Email:			
Mobile:		Fixed line:	
DOB :	____/__ __/_____	Occupation:	
Gender:		Marital status	
NHS no.		State Preferred no.	

GP / GDP details

GP name:		Phone	
Practice:		Address:	
Postcode:		Email:	

Please tick the box if you suffer from any of the following conditions:

Muscular / Skeletal problems:

Neck		Rheumatism		Arthritis		Back	
Aches & pains		Stiff joints					

Digestive problems:

Constipation		Bloating		IBS	

Circulation problems:

Heart		High Blood pressure		Low Blood pressure		Fluid retention	
Tired legs		Varicose veins		Cellulite		Cold hands & feet	

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Gynaecological problems:

Irregular periods		PMT		Menopause		HRT	

Nervous system:

Migraine		Tension		Headaches		Stress	
Depression							

Immune system:

Prone to infections		Colds		Sinuses		Sore throats	

What is your skin type:

Dry		Oily		Combination		Dehydrated	
Sensitive							

Do you suffer from any of the following?

	YES	NO		YES	NO
Dermatitis			Acne		
Psoriasis			Allergies		
Hay fever			Asthma		
Eczema					

Are you on medication? YES / NO (Please circle)

If yes, please provide details	

Are you pregnant? YES / NO (Please circle)

Do you have a pacemaker? YES / NO (Please circle)

Comprehensive Clinical details and Reasons for Referral:

Disclaimer

I agree to receive treatment from the therapists under T4H or their partners:

Signature:	Date: ____/____/_____

NB. Your confidentiality is maintained at all times

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