

ULTRASOUND REQUEST FORM

For echocardiography, please use physiological measurement request form

PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR PATIENTS UNDER 18 YEARS OF AGE
PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR BREAST ULTRASOUND

<p>Patient ID</p> <p>NHS Number _____</p> <p>First Name _____</p> <p>Surname _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Date of Birth _____</p> <p>Telephone (Home) _____</p> <p>Telephone (Work) _____</p> <p>Telephone (Mobile) _____</p> <p>Email Address _____</p> <p>Gender Male <input type="checkbox"/> Female <input type="checkbox"/></p>	<p>Referring Clinician</p> <p>Name _____</p> <p>GMC/HPC/NMC No. _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Referring PCT Code _____</p> <p>Referring Practice Code _____</p> <p>Telephone No. (For urgent clinical findings) _____</p> <p>Fax No. _____</p> <p>NHS Mail (nhs.net only) _____</p>
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<p>Physical/Communication difficulties (Specify if any) _____</p> <p>_____</p> <p>If interpreter required, language _____</p> <p>Religion _____</p> <p>Ethnicity _____</p>	<p>Eligible for NHS Funded Transport Yes <input type="checkbox"/></p> <p>Car Transport Required Yes <input type="checkbox"/></p> <p>Wheelchair User Yes <input type="checkbox"/></p> <p>The patient must be ambulant, or if a wheelchair user they must be able to transfer independently on to the scanner or examination couch.</p>
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Clinical Indication/Problem/Provisional Diagnosis

Please provide as much relevant clinical information to ensure the most appropriate investigation is performed in accordance with the Royal College of Radiologists' guidelines.

Allergies:

Relevant Past Medical History (Include previous and current treatment/medication where relevant)

Diabetic? Yes No

Notes/Documentation attached? Yes No

Investigation(s) Required *Tick all required; please indicate which side where appropriate.*

<p><input type="checkbox"/> Abdomen (upper)</p> <p><input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Musculoskeletal (specify area & side) _____</p> <p>_____</p> <p><input type="checkbox"/> Pelvis & Abdomen</p> <p><input type="checkbox"/> Pelvis (Gynae): Transabdominal</p> <p><input type="checkbox"/> Pelvis (Gynae): Transvaginal</p> <p><input type="checkbox"/> Pelvis (Other)</p> <p><input type="checkbox"/> Prostate (Transrectal)</p> <p><input type="checkbox"/> Salivary Gland <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Scrotum</p>	<p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Urinary Tract</p> <p><input type="checkbox"/> Doppler: Carotids</p> <p><input type="checkbox"/> Doppler: Lower Limb <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Doppler: Scrotum</p> <p><input type="checkbox"/> Doppler: Penile</p> <p><input type="checkbox"/> Lump/Cyst (specify body part) _____</p> <p><input type="checkbox"/> Other (Specify below) _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Referrer's Signature Date of request ___/___/___