

**PATIENT DETAILS:**

Name: NHS Number:  
 Date of Birth: Gender: Male Female  
 Address: Tel Number:  
 \*Mobile Number:  
 Postcode: Email:  
 Interpreter Required: Yes No  
 If interpreter required which language:  
 Ethnic Origin:  
 Pregnancy status: Not Pregnant Pregnant  
 LMP: If yes: Gestation weeks:

*\*please note patients may receive text messages regarding their appointment*

**SERVICE SPECIFIC REFERRAL INFORMATION:**

Priority: Routine: Urgent:

**Examination Requested** including body area to be imaged:

X-ray Ultrasound MRI

CT For CT please state eGFR: Diabetic status: Allergies:

Relevant Clinical Information: (as examination is protocol based, the quality of this information is important:

Question to be answered:

**REFERRING CLINICIAN:**

Referrer Name: Date of Referral:  
 GMC number: Tel Number:  
 Referring Practice:  
 Practice Address:  
 Postcode :

Authorised by signature of referring  
 clinician):