**ROUTINE URGENT**

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| --- | --- | --- | --- |
| Patient title & full name: |  | Male: [ ] Female: [ ] | |
| NHS Number: |  | D.O.B: |  |
| Address: |  | Tel: |  |
|  |  | Mobile |  |
| Postcode: |  | Email: |  |

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| --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **REFERRER’S CCG** |  |   **(NAME AND ADDRESS IN ORDER TO RECEIVE REPORT)** | | **REFERRER’S STAMP** |
| Name: |  |  |
| Address: |  |
|  |  |
| Postcode: |  |
| Telephone: |  |
| **Fax:** |  |
| **Email:** |  |

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| **ULTRASOUND SCAN REQUESTED**  **(PLEASE TICK ALL THAT APPLY)** | | **CLINICAL INFORMATION / CLINICAL QUESTION TO BE ANSWERED:** |
| **Abdomen:** |  |  |
| **Abdomen & Pelvis:** |  |
| **Pelvis:** |  |
| **Pelvis/ Transvaginal (TV):** |  |
| **Urinary Tract (KUB):** |  |
| **KUB & Prostate:** |  |
| **Musculoskeletal (MSK):** |  |
| **Testes:** |  |
| **Hernia:** |  |
| **Other:** |  |

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| **Special Requirements:** |  | | |
| Mobility assistance: |  | Other: |  |

EXCLUSIONS

* BREAST SCAN
* AXILLA SCAN
* THYROID SCAN
* UNDER 18
* CANCER KNOWN SITE