** REFERRAL FORM

 PATIENT DETAILS

Mr Mrs Miss Dr Other (please specify):

First name:

Surname:

Date of birth:

☐Male ☐Female

NHS Number

Email:

Telephone:

Address:

Post code:

Policy number:

Self-pay/Insured:

Insurer name:

 RELEVANT CLINICAL DETAILS

**\*Please ensure these boxes are completed**

**\***Region(s) to be Imaged:

**\***Justification for Imaging:

X-Ray☐ Ultrasound☐

|  |  |  |  |
| --- | --- | --- | --- |
| **\***Is the patient pregnant? | ☐Yes | ☐No | If yes; do you wish to proceed with the exam and have you explained to the patient? ☐Yes ☐No |

Urgent exam? ☐Yes ☐No Infection risk? ☐Yes ☐No Needs Translation? ☐Yes ☐No

 If yes, give details If yes, language?

## REFERRING CLINICIAN’S DETAILS

Mr. Mrs. Miss Dr Other (please specify):

Please confirm how you would like to receive the report by ticking below:

☐**Email** ☐**Post**

Send this image/report to local NHS/another clinician? ☐Yes ☐No

If yes, please provide details: -------------------------------------------------------

Referrer name:

Specialty/profession:

Registration code:

Hospital/practice:

Email:

Address:

Signature: **\*** Date:

Post code:

Tel:

Fax:

 **When completed - please email** this form to enquiries@radpidiagnostics.com

Radpid Diagnostics 599-613 Princes Road, Dartford, DA2 6HH United Kingdom

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\*\*\*\*This form is to be shredded once scanned onto the Radiology system.

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