Radpid Diagnostics
POINT OF CARE MEDICAL IMAGING

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**

*Justification for Imaging:

*Region(s) to be Imaged:

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
If yes, give details
Needs Translation? ☐Yes ☐No
If yes, language?

REFERRING CLINICIAN'S DETAILS

Mr. Mrs. Miss Dr Other (please specify):
Referrer name:
Specialty/profession:
Registration code:
Hospital/practice:
Email:
Address:
Post code:
Tel:
Fax:

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: ----------

Signature: *
Date:

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