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| **Description: InHealth Logo (Smaller).jpg** | **NHS logo** |

**X-RAY REFERRAL FORM**

**Please note – we are unable to accept referrals for patients under 16 years of age**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT** | | | | **REFERRER** | | | | | |
| NHS Number |  | | | Name | | |  | | |
| First name |  | | | GMC/HCPC/NMC No | | |  | | |
| Last Name |  | | | Address | | |  | | |
| Address |  | | |  | | |  | | |
| Date of Birth |  | | | Referring CCG Code | | |  | | |
| Telephone (Home) |  | | | Referring Practice Code | | |  | | |
| Telephone (Work) |  | | | Telephone No.  (**for urgent clinical findings)** | | |  | | |
| Telephone (Mobile) |  | | | Fax No. | | |  | | |
| E-mail Address |  | | | NHS.net mail only | | |  | | |
| Gender | Male  Female  Gender neutral | | | Eligible for and does require NHS funded transport?  **(car transport only)** Yes | | | | | |
| Physical/Communication difficulties (specify if any): | | | | Wheelchair user? Yes | | | | | |
| If interpreter required, language: | | | | The patient must be ambulant, or if a wheelchair user they must be able to transfer independently onto the examination couch. | | | | | |
| Ethnicity | | | |  | | | | | |
| **PRESENTING COMPLAINT & PROVISIONAL DIAGNOSIS**  Please provide as much relevant clinical information as possible to ensure the most appropriate investigation is performed in accordance with the Ionising Radiation (Medical Exposure) Regulations 2017 and the 2017 Royal College of Radiologists’ Referral Guidelines.  If the clinical information you provide indicates that the X-ray requested is inappropriate we will contact you to suggest alternative imaging techniques.    Date of Referral:      Referrer’s Signature:  *This form must be signed by the referrer to comply with IR(ME)R* | | | | | | | | | |
| **Investigation(s) Required:** tick all required; please tick the boxes to indicate which side where appropriate  **Are standing views required yes/no** | | | | | | | | | |
| Abdomen | |  | Hand | | L  R | Scapula | | | L  R |
| Ankle | | L  R | Heel | | L  R | Shoulder | | | L  R |
| Cervical Spine | |  | Hip | | L  R | Skeletal Survey | | |  |
| Chest | |  | Humerus | | L  R | Thoracic Spine | | |  |
| Clavicle | | L  R | Knee | | L  R | Tibia/Fibula | | | L  R |
| Elbow | | L  R | Lumbo-Sacral Spine | |  | Wrist | | | L  R |
| Facial Bones | |  | Mandible | |  | Other (please) specify body part and side): | | | |
| Femur | | L  R | Orbits | |  |  | | | |
| Foot | | L  R | Pelvis | |  |  | | | |
| Forearm | | L  R | Scaphoid | | L  R |  | | | |
| **For X-Ray examinations of persons of child-bearing capability (aged 10-55 years), is there any possibility of the patient being pregnant?**  Yes  No  Date of last menstrual period | | | | | | | | | |
| **Please fax or e-mail this form to the InHealth Patient Referral Centre:**  **Fax: 0333 200 1163 E-mail:** [**inl.inhealthreferrals@nhs.net**](mailto:inl.inhealthreferrals@nhs.net)  **Tel: 0333 202 0297** | | | | | | | | **www.inhealthgroup.com**  **Issue Jan 2021 / Review Jan 2026**  **Version 4** | |