BRIGHTON AND HOVE CLINICAL COMMISSIONG GROUP

Referral Form – Ultrasound Scanning (non-obstetric)

PATIENT DETAILS	**GP DETAILS**
Name:	**Name:**
Address: **Postcode:**	**Practice Address:** **Postcode:**
Home Tel:	**Telephone:**
Mobile Tel:	**Referring practice code:**
Work Tel:	**Referring PCT Code:**
D.O.B:	**Fax:**
NHS Number:	**NHS email (nhs.net only):**
Gender:	**Registered Practice:** **(if different)**
Ethnicity:	
Interpreter language (if required):	
Religion:	**Date of referral:**

SCANNING REQUEST:

Routine ☐ Urgent ☐

Abdo ☐ Renal ☐ Pelvis ☐ Testes ☐ MSK ☐

Right ☐ Left ☐

Clinical question to be answered by the scan

Clinical condition / symptoms and clinical indication including relevant past medical and drug history (include previous and current treatment/medication/allergies where relevant) (Include any special requirements e.g. contact only by post OR text, mobility issue, sensory impairment)

Send this referral by Choose and Book to the provider of the patient's choice