ULTRASOUND REFERRAL FORM

We are unable to accept referrals for patients under 18 years of age
We are unable to accept referrals for breast or obstetric ultrasound

PATIENT		**REFERRER**	
NHS Number		Name	
Forename		GMC/HPC/NMC No	
Surname		Address	
Address			
Date of Birth		Referring PCT 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 ☐	Ethnicity	
Physical/Communication difficulties (specify if any):		Wheelchair user? Yes ☐ The patient must be ambulant, or if a wheelchair user they must be able to transfer independently onto the examination couch.	
If interpreter required, language:			

PRESENTING COMPLAINT & PROVISIONAL DIAGNOSIS
Please provide as much relevant clinical information as possible to assist with the interpretation of the referral and images. GP referral guidelines are available from our website www.inhealthgroup.com

Date of Referral:

Investigation(s) Required: tick investigation required; please indicate which side of body and body part where appropriate.

General Ultrasound Clinic:		**Musculoskeletal Clinic:**		**Vascular Clinic:**	
Upper Abdomen (will include abdominal aorta)	☐	Musculoskeletal (indicate specific area/joint) ----------	L R ☐☐	Doppler – Carotid Arteries	☐
Female Pelvis (will include TVS if indicated)	☐	Suspected hernia: Groin & Inguinal Region Anterior Abdominal Wall	L R ☐☐ ☐	Doppler – Lower Limb Arteries	L R ☐☐
Urinary Tract (for male patients prostate will be included)	☐	Superficial lumps/bumps **no breast, axilla, groin or neck masses* ----------	☐	Doppler – Lower Limb Veins	L R ☐☐
Testes	☐				

Please post, fax or e-mail this form to the InHealth Patient Referral Centre:
Sandbrook House, Sandbrook Way, Rochdale OL11 1RY
Tel: 0845 437 0347 Fax: 0845 437 0348 E-mail: INL.inhealthreferrals@nhs.net

www.inhealthgroup.com
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