|  |  |
| --- | --- |
| **InHealth Logo (Smaller).jpg** | **C:\Documents and Settings\Darren.Bourne\Desktop\NHS Logo.png** |

**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 |
| **Upper Abdomen** (will include abdominal aorta) | [ ]  | **Female Pelvis** (will include TVS if indicated) | [ ]  | **Urinary Tract**(for male patients prostate will be included) |  [ ]  | **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****Version: Jan 2013** |