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| **LLR Provider Company** |  **InHealth** | **NHS**  |

**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**

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| **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 [ ]  | Wheelchair user? Yes [ ]  |
| Physical/Communication difficulties (specify if any): |
| 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~[Ethnicity] |
| **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.comDate 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: February 2013** |