

GP Imaging Referral



PLEASE COMPLETE A SEPARATE REFERRAL FOR EACH IMAGING MODALITY REQUIRED PLEASE ENSURE THIS REFERRAL IS COMPLETED FULLY, FAILURE TO DO SO MAY RESULT IN A DELAY

PATIENT DETAILS	REFERRING CLINICIAN (Doctor only)
Name:	Name:
Address:	
Post code	Address:
Date of birth: Telephone: (home) (mobile)	7.23.55
Telephone:	Post code:
Eligible for transport: Yes No Transport required: Yes No	Telephone:
If Interpreter required, language?	Email:
INVESTIGATION REQUIRED	
Knee ULTRASOUND □ XRAY □ MRI (COMPL	ETE SECTION BELOW)
Hip ULTRASOUND □ XRAY □	
ULTRASOUND ONLY	
Elbow	Ankle
Soft Tissue / Lump	
Shoulder - Please note: For Ultrasound requests of the shoulder please use the	e separate dedicated referral form.
CLINICAL INDICATIONS	
(Referral should be made in line with The Royal College of Radiologisi	s Imaging Referral Guidelines
(Relettal Stibulu de Itlade III line with The Royal College of Radiologis	s illiaging Neierral Guidelines)
Is there any possibility of the patient being pregnant? Yes □ No □	Date of last menstrual period (dd/mm/yyyy):
Is there any possibility of the patient being pregnant? Yes □ No □ Patient Allergies	Date of last menstrual period (dd/mm/yyyy):
Patient Allergies	
Patient Allergies	arfarin YES NO
Patient Allergies Is the patient: Diabetic YES NO Patient on W MRI KNEE REFERRALS ONLY R L Suspected Meniscal Tear Other reason (Suspected Ligament Damage	arfarin YES NO
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