

Ultrasound Request Form

HIGHLY CONFIDENTIAL

Please complete all sections of this request form and send it to:

NHS No.	UBR No.
Surname:	
First Name:	Middle Initial:
Male/Female:	Date of Birth:
Address:	
	Post Code:
Tel No (home):	(mobile):

Ultra

Send referrals by secure post to your local Primary Care Trust

Referring Clinician Name:
Referring Clinician Address:
NHS Mail Address:

GP Name:
GP Address:
NHS Mail Address:

Weight (Kg) _____

Is the patient an infection risk (e.g. MRSA)? _____

Is the patient diabetic? (if yes please specify treatment): _____

Current medication? (please specify): _____

Interpreter required? (if yes specify language): _____

Please specify if patient requires: Stretcher Wheelchair Other: _____

Any special needs e.g. hearing, mobility, speech or other? (if yes please specify): _____

Examination requested:

Please state date, location and type of relevant previous investigations:

Clinical history/indications for the examination and clinical question to be answered:

Referring Clinician (Print):
Referring Clinician (Signature):
Date of referral
GMC no. / GP no. or equivalent

In some instances the person performing the scan can give the patient a verbal report of the findings at the end of the examination. Is there any reason why this is not appropriate for this patient? Yes No

Office Use only

Operator's Signature: _____