CT Referral Form

Alliance Medical

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):

CT

Alliance Medical
Patient Management Centre
Iceni Centre
Warwick Technology Park
Warwick, CV34 6DA

GP Name:

GP Address:

NHS Mail Address:

Medical Information *(If yes please specify):*

Could the patient be pregnant?

LMP date:

Does the patient have any allergies?

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

Is the patient diabetic?

If yes is the patient prescribed metformin?

Interpreter required? *(If yes specify language):*

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:

Referrer's declaration:

I have discussed the examination with the patient and have considered the possibility of pregnancy. I understand my obligations under IR(ME)R 2000.

Referring Clinician *(Print):*

Referring Clinician *(Signature):*

NHS mail address

GMC no. / GP no. or equivalent

Office Use only

Operator's Signature:

Signatory confirms authorisation against justification guidelines, patient identification procedure and is responsible for initiating the exposure.