|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Inclusion Criteria** | | | | | **Exclusion Criteria** | | | |
| **•Registered with a GP** | | | | |  | | | |
|  | | | | | | | | |
| 1. **PATIENT DEMOGRAPHIC DETAILS** | | | | | | | | |
| NHS number : | | |  | | | | | |
| First Name: | | |  | | | Last name |  | |
| Date of Birth (DD/MM/YY): | | |  | Gender | | Male | Female | |
| Address (1st Line): | | |  | | | | | |
| Town/City: | | |  | | | Post Code |  | |
| Contact Number\*: | | |  | | | Other contact |  | |
| Interpreter Required Yes/NO | | | If yes – which language | | | Ethnic origin | Mobility (hoist required) | |
| Impairments | | | Sight: | | | Speech: | Hearing: | |
| Pregnancy status Yes/NO | | | LMP | | | If yes –Gestation weeks |  | |
| 1. **REFERRER- complete the following section** | | | | | | | | |
| Referrer Name |  | | | | | GMC number | |  |
| Referring Practice |  | | | | | | | |
| Practice Address |  | | | | | | | |
| Postcode |  | | | | | Telephone Number | |  |
| Date of Referral |  | | | | | Referrer Signature\*\* | | |
| **2b. NOT REGISTERED – complete the following section if not registered** | | | | | | | | |
| nhs.net e-mail address: | |  | | | | | | |
| Contact number | |  | | | | | | |

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| 1. **EXAMINATION REQUESTED: including body area to be imaged:** |
| Priority: Routine:  Urgent:  **Ultrasound Examination Requested** : If unsure about which exams to request please check **iRefer on-line**  **Abdo  KUB  Pelvis  MSK  Soft Tissue  Other (please specify)**  Diabetic status:       Allergies:  Specific Clinical Information: (as examination is protocol based, the quality of this information is important) |
| Question to be answered/Suggested Exam: |

**\*Patients may recived text messages regarding the referral made from Guys & St Thomas’ Hospital**

**\*\*An electronic signature will be accepted**

**Once Completed, all referrals must be sent via e-RS -** This service is mapped to Diagnostic Imaging:

When referring the patient, please ensure that you advise the patient that you will be booking them a dummy appointment which they must **NOT** attend.

Once the referral form has been attached to the dummy appointment, it will be available to us for processing.  We will triage the referral and contact the patient to book them their appointment as scan times will vary upon the request.

|  |  |  |
| --- | --- | --- |
| **Specialty** | **Clinic type** | **Service name** |
| Diagnostic Imaging | Ultrasound | Diagnostic Ultrasound Assessment Service (patient does not attend) - Guy's & St Thomas's- RJ1 |