|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Inclusion Criteria** | | | | | **Exclusion Criteria** | | | |
| **•Registered with a GP**  **•Aged 18 or over** | | | | | **•Pregnant**  **•Those receiving end of life care** | | | |
|  | | | | | | | | |
| 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 | |  | | | | | | |

|  |  |  |
| --- | --- | --- |
| 1. **EXAMINATION REQUESTED including body area to be imaged:** | | |
| Priority: Routine:  Urgent:  Specific Clinical Information (as examination is protocol based, the quality of this information is important and should follow current NICE and iRefer guidelines):  Diabetic status:       Allergies: | | |
| Question to be answered/Suggested Exam: | | |
| 1. **CLINICAL CHECKLIST** | | |
| **LMP** | Date |  |
| For fluoroscopy procedures, patients must be within 10 days of the 1st day of their last period. Pregnancy test results will not be accepted. | | |

**\*Patients may receive 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 | Fluoroscopy | Diagnostic Fluoroscopy/ Assessment Service (patient does not attend) - Guy's & St Thomas's- RJ1 |