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| **Inclusion Criteria** | | | | | **Exclusion Criteria** | | | |
| **•Registered with a South East London GP (Lambeth, Southwark, Lewisham, Bromley, Greenwich, Bexley)**  **•Aged 18 or over**  **•BMI ≥40**  **•BMI ≥35 with Type 2 Diabetes**  **Musculo-skeletal referrals**  **Neurological non-complex referrals** | | | | | **•Pregnant**  **•Those receiving palliative or end of life care** | | | |
| **\*\*\*Consider direct referral to bariatric service (Tier 4) if BMI ≥50 or ≥35 with complex co-morbidities\*\*\*** | | | | | | | | |
| 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:** | | |
| Clinical Information/Concern: (as examination is protocol based, the quality of this information is important) | | |
| Question to be answered/Suggested Exam: | | |
| 1. **MRI CLINICAL CHECKLIST** |  |  |
| **Pacemaker or any implanted devices? E.g. cochlear implant, spinal cord stimulator** | Yes  No  If Yes please complete details | Device details: |

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

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

**Once Completed, all referrals must be sent via e-RS -** This service is cross mapped to Diagnostic Imaging, but all patients will be seen by the relevant Guys & ST Thomas’ Radiology Service.

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| **Specialty** | **Clinic type** | **Service name** |
| Diagnostic Imaging | CT | Radiology |
| Diagnostic Imaging | MRI | Radiology |
| Diagnostic Imaging | Ultrasound | Radiology |
| Diagnostic Imaging | Fluoroscopy | Radiology |