

Request for Ultrasound Scan

Patient No. _____

WLI No. _____

3fivetwoTM
HEALTHCARE

Referrers are required to complete sections 1-4 accurately and legibly. Inadequately completed forms will not be accepted.

1 Patient Details print or affix addressograph or label

Surname: _____ Forename: _____ Title: _____

Date of Birth: _____ Gender: Male / Female (Delete as appropriate)

Address: _____

Post Code: _____ Tel (Home): _____ Mobile: _____

Patient Identification: I have confirmed the above patients name, address and DOB. Signed: _____
For 3fivetwo

Healthcare use only. Verified by patient: If another / Status: _____ Signed: _____

2 Cautions (if none, tick here)

Diabetes mellitus

No If Yes / Controlled by: Insulin Glucophage / metformin
 Diet Other / Specify: _____

Other cautions

Blind Impaired cognitive functioning
 Deaf Other / Specify: _____
 Mobility

Infection risk to staff

MRSA
 Category 3
 Other (Specify): _____

3 Clinical Details / Notes: Please include provisional diagnosis or indication and indicate results of previous tests / imaging if applicable.

You are legally obliged under IR(ME)R NI 2000 to supply sufficient medical data for justification purposes.

4 Examination / procedure requested: _____

Referrer (print name): _____ Signature: _____

Address: _____ Post Code: _____

For operator / practitioner use only

Examination / procedure authorised by: _____ Date: _____
(subject to a decision to proceed following completion of pregnancy status section on reverse, if relevant)

Assigned to (Radiologist): _____

Reported Report sent Disc sent Date sent

Address sent to: _____

Post Code: _____ Tel (Home): _____ Mobile: _____

Pharmaceutical prescription & Administration

Name:	Strength:	Dose / quantity:	Batch no. & Expiry date:	Drawn up by:	Checked by:
Prescribers signature:			Administered by:		

Notes

- Aorta
- IVC
- Gall bladder
- CBD
- Liver
- Right kidney
- Left kidney
- Pancreas
- Spleen
- Bladder
- Uterus
- Right ovary
- Left ovary
- Prostate
- Other

For 352 Admin use: This patient is: Insured Self Funding Waiting List Initiative Employer Occ Health / Screen
Insurance Company / Trust: _____
Policy Number: _____ Authorisation Number: _____

