

Request for Ultrasound Scan



Patient No. _____

WLI No. _____

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: For 3fivetwo Healthcare use only. I have confirmed the above patients name, address and DOB. Signed: _____
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: _____ Date: _____

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)

