# OneWelbeck Urology Patient Booking Form

*Please complete all sections of the form. By completing this form, you confirm you have the consent required to share this information.*

## PATIENT DETAILS

TITLE: FORENAME(S): SURNAME:

DATE OF BIRTH: GENDER: ☐ Male ☐ Female ☐ Other:

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

## REFERRAL DETAIL

☐ Consultation with Uroradiologist ☐ Consultation with Urology Consultant

Tests/Procedures

☐ US kidneys (US renal; NOT renal doppler)
☐ US urinary tract (US renal tract; US kidneys and bladder)
☐ US urinary tract and flow rate (USUD)
☐ US bladder
☐ US bladder and flow rate (USCD)
☐ US transrectal prostate; TRUS
☐ US testes (US scrotum)
☐ US penis (NOT penile doppler with Caverject)
☐ US abdomen
☐ US abdomen and pelvis
☐ US gallbladder
☐ US aorta
☐ Other, please provide details:

INDICATION, REASON FOR REFERRAL, MEDICAL HISTORY AND CLINICAL DETAILS (REQUIRED):

Please complete the below for tests/procedures:
KNOWN ALLERGIES:

BLOOD THINNING MEDICATION:

## GP (OR OTHER REFERRER) DETAILS

GP/REFERRER NAME: GP/REFERRER PRACTICE:

GP/REFERRER CONTACT NUMBER: GP/REFERRER EMAIL:

## PAYMENT DETAILS (IF KNOWN)

TYPE: Self-funding ☐ Insured ☐ Embassy ☐ Other (please complete below sections as appropriate)

INSURANCE COMPANY: MEMBERSHIP NO: AUTHORISATION CODE:

EMBASSY: LETTER OF GUARANTEE: ☐ Yes (please attach)

## EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS: WHEELCHAIR ACCESS: ☐

INTERPRETER REQUIRED: ☐ Yes, please confirm language:

OTHER:

## DECLARATION & FORM SUBMISSION

*I authorise this patient to undergo the above procedure and I hereby prescribe the above listed bowel preparation.*

NAME: SIGNED: DATE:

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:
E: bookings.menshealth@onewelbeck.com
A: Bookings, OneWelbeck Men's Health, 1 Welbeck Street London W1G 0AR
T: +44 (0)203 653 2042