OneWelbeck
Imaging & Diagnostics

Imaging Referral Form

Please complete all sections of the form and return to bookings.diagnostics@onewelbeck.com.

RESULTS PORTAL - PLEASE CONTACT US TO GAIN ACCESS

PATIENT DETAILS

TITLE: FORENAME(S): SURNAME:

MRN:

DATE OF BIRTH: GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

REFERRAL DETAIL

☐ X-Ray
☐ DEXA (please include details of previous imaging)
☐ CT Scan
☐ Standing CT for foot & ankle
☐ MRI
☐ Ultrasound

EXAM:

CLINICAL DETAILS:

If for MRI scan, please ensure patient has no contraindications to MRI:

Pacemaker/Defibrillator/loop recorder ☐ Yes ☐ No
Aneurysm clips ☐ Yes ☐ No
Cochlear Implants ☐ Yes ☐ No
☐ Is the patient diabetic
☐ Known renal impairment

Preferred Radiologist

Examinations cannot be performed without enough clinical information (Ionizing Radiation (Medical Exposure) Regulations 2017):

EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS: WHEELCHAIR ACCESS: ☐

INTERPRETER REQUIRED: ☐ Yes, please confirm language:

OTHER:

REFERRER DETAILS

GP/REFERRER NAME : GP/REFERRER PRACTICE :

GP/REFERRER CONTACT NUMBER: GP/REFERRER EMAIL:

PAYMENT DETAILS (IF KNOWN)

☐ Bill to Patient

☐ Bill to Insurer
INSURANCE COMPANY:
MEMBERSHIP NO:
AUTHORISATION CODE:

☐ Bill to Embassy
EMBASSY:
LETTER OF GUARANTEE: ☐ (Please attach)

☐ Bill to referrer
AGENCY NAME:

NAME : SIGNED : DATE :

PROFESSIONAL REG NO :

RADIOGRAPHER USE:

ENSURE LMP, DOSE, RADIOGRAPHER INITIALS AND CONTRAST INFORMATION ARE RECORDED ON COMPUCARE

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: