OneWelbeck Women's Health Ultrasound Referral Form

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

PATIENT DETAILS		
TITLE:	FORENAME(S):	SURNAME:
MRN:	DATE OF BIRTH:	GENDER: ☐ FEMALE ☐ MALE ☐ OTHER
RESIDENTIAL ADDRESS:		
		POSTCODE:
TELEPHONE:		MOBILE:
EMAIL:		REGISTERED AT ONEWELBECK? Yes ☐ No ☐ Don't know ☐

REFERRAL DETAIL

☐ Transvaginal pelvic ultrasound scan
☐ Transabdominal pelvic ultrasound scan
☐ Abdominal ultrasound scan
☐ HyCoSy
☐ DEXA
☐ Other:

DATE OF REQUEST:

CLINICAL DETAILS:

Preferred Consultant:

Has the patient previously tested positive for COVID-19 (Coronavirus)
Within the last 10 days?

Yes ◯ No ◯
If yes; please provide a negative antigen test result or contact
bookings.womenshealth@onewelbeck.com

REFERRER DETAILS	
GP/REFERRER NAME:	PROFESSIONAL REG NO:
GP/REFERRER PRACTICE:	
GP/REFERRER CONTACT NUMBER:	GP/REFERRER EMAIL:
ADDRESS FOR REPORT:	

PAYMENT DETAILS (IF KNOWN)		
TYPE: Self-funding ☐ Insured ☐ Embassy ☐ Other (please complete below sections as appropriate)		
INSURER:	AUTHORISATION CODE:	MEMBERSHIP NO:
EMBASSY:		LETTER OF GUARANTEE: ☐ Yes (please attach)

EXTRA REQUIREMENTS	
SPECIAL EQUIPMENT REQUIREMENTS:	WHEELCHAIR ACCESS: ☐
INTERPRETER REQUIRED: ☐ Yes, please confirm language:	
OTHER:	

By completing this form, you confirm you have the consent required to share this information.

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.womenshealth@onewelbeck.com
A: Bookings, OneWelbeck Women's Health, 1 Welbeck Street London W1G 0AR
T: +44 (0)203 6532008