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):

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) ☐

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:

DECLARATION

NAME: SIGNED: DATE:

PROFESSIONAL REG NO:

Radiographer Use:

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

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.diagnostics@onewelbeck.com
A: Bookings, OneWelbeck Imaging and Diagnostics, 1 Welbeck Street London W1G 0AR
T: +44 (0)203 6532001