OneWelbeck

Imaging Referral 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:

MRN:

DATE OF BIRTH: GENDER: ☐ Male ☐ Female ☐ Prefer not to say

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

REFERRAL DETAIL

☐ X-Ray
☐ US
☐ USGI
☐ CT
☐ Cardiac CT
☐ Contrast

If YES please provide eGfr ....

☐ MRI
☐ Cardiac MRI

If YES please ensure patient has no contraindications to MRI:

Pacemaker YES ☐ NO ☐
Aneurysm clips YES ☐ NO ☐
Cochlear Implants YES ☐ NO ☐

☐ Standing CT

Preferred Radiologist:

EXAM:

CLINICAL DETAILS:
Examinations cannot be performed without sufficient 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)

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

I confirm all details are correct to the best of my knowledge.

NAME: SIGNED: DATE:

PROFESSIONAL REG NO:

Radiographer Use:

OPERATOR:	For women of childbearing potential LMP:
JUSTIFIED BY:	Is there any possibility you could be pregnant YES/NO
DOSE (include units):	Signed:

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: info@welbeckhealth.com
A: Bookings, OneWelbeck Heart Health, 1 Welbeck Street London W1G 0AR
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