Imaging Referral Form

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

PATIENT DETAILS

TITLE: FORENAME(S): SURNAME:

RESIDENTIAL ADDRESS:

POSTCODE: GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

MRN: DATE OF BIRTH:

TELEPHONE: MOBILE:

EMAIL:

REFERRAL DETAIL

☐ X-Ray
☐ Ultrasound
☐ CT Scan
☐ Standing CT for lower limb
☐ MRI

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:

Has the patient previously tested positive for COVID-19 (Coronavirus)

Yes ☐ No ☐

If yes; please provide a negative antigen test result or contact bookings.diagnostics@onewelbeck.com

EXAM:

CLINICAL DETAILS:

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:

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

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)20 3653 2001