

## Imaging Referral Form

Please complete all sections of the form and return to [bookings.diagnostics@onewelbeck.com](mailto:bookings.diagnostics@onewelbeck.com).  
N.B. This form **must** have a signature - referrers should either use e-signature software, or print out the form to fill and sign before scanning and sending to OneWelbeck.

PATIENT DETAILS		
TITLE:	FORENAME(S):	SURNAME:
RESIDENTIAL ADDRESS:		
POSTCODE:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	
MRN:	DATE OF BIRTH:	
TELEPHONE:	MOBILE:	
EMAIL:		

REFERRAL DETAIL	
<input type="checkbox"/> X-Ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> CT Scan <input type="checkbox"/> Standing CT for lower limb <input type="checkbox"/> MRI	Has the patient previously tested positive for COVID-19 (Coronavirus) Yes <input type="checkbox"/> No <input type="checkbox"/> If yes; please provide a negative antigen test result or contact <a href="mailto:bookings.diagnostics@onewelbeck.com">bookings.diagnostics@onewelbeck.com</a>
If for MRI scan, please ensure patient has no contraindications to MRI:  Pacemaker/Defibrillator/loop recorder <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clips <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear Implants <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Is the patient diabetic <input type="checkbox"/> Known renal impairment	<b>EXAM:</b> <b>CLINICAL DETAILS</b>
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 <input type="checkbox"/> Insured <input type="checkbox"/> Embassy <input type="checkbox"/> Other (please complete below sections as appropriate)		
INSURER:	AUTHORISATION CODE:	MEMBERSHIP NO:
EMBASSY:	LETTER OF GUARANTEE: <input type="checkbox"/> Yes (please attach)	

EXTRA REQUIREMENTS	
SPECIAL EQUIPMENT REQUIREMENTS:	WHEELCHAIR ACCESS: <input type="checkbox"/>
INTERPRETER REQUIRED: <input type="checkbox"/> 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](mailto:bookings.diagnostics@onewelbeck.com)  
 A: Bookings, OneWelbeck Imaging and Diagnostics, 1 Welbeck Street London W1G 0AR  
 T: +44 (0)20 3653 2001