**ULTRASOUND REFERRAL FORM – VIA ASHFORD CLINICAL PROVIDERS**

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| **Patient details** | **Referrer details** |
| Title: Title  | Name: Referrer name  |
| Forename: Given Name  | Address: Referrer address |
| Surname: Surname  |  |
| Address: Home Full Address (single line)  | Postcode: Referrer postcode  |
|  | GP Practice Code: Referrer code |
| Postcode: Home Address Postcode  | Tel: Referrer tel |
| Birth Date: Date of Birth  | From Email: Referrer email |
| Tel (Home): Patient Home Telephone  | To Email: NHS Email for receipt of Ultrasound electronic report |
| Tel (Work): Patient Work Telephone  |  |
| Tel (Mobile): Patient Mobile Telephone  | Date of Referral: Date |
| Email Address: Patient E-mail Address  |  |
| Gender: Gender(full)  |  |
| NHS Number: NHS Number  |  |
|  | Assistance Required: [ ] Yes [ ] No  |
| Ethnicity: Ethnic Origin  | Interpreter Required: [ ] Yes [ ] No  |
| First Language: Main Language  | Chaperone Required: [ ] Yes [ ] No  |
| **ULTRASOUND SCAN REQUEST** **Exclusions** - Breast, obstetric, cardiac imaging, chest, ophthalmology, groins for hernias, MSK and thyroids) **Please ”X” the type of ultrasound required** | Clinical Condition / Symptoms and Clinical Indication (including relevant previous medical history): **Enter details** |
| [ ] Abdomen | [ ] Female Pelvis/TV  | What question would you like this examination to answer?**Enter details** |
| [ ] Pre & Post Bladder void  | [ ] Lumps & Bumps (cysts, lipomas, baker cysts)  |
| [ ] KUB  | [ ] Scrotal  |
| [ ] Carotids(Includes suspected DVT) |   |
| **Charing Outpatients Admin**APPOINTMENT DATE: TIME: |