**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: | |