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| **Patient details** | | | **Referrer details Mandatory PLEASE** | |
| Title: | | | Name: <Surgery's Name> | |
| Forename: | | | Address: | |
| Surname: | | |  | |
| Address: | | | Postcode: | |
|  | | | GP Practice Code: | |
| Postcode: | | | Tel: <GP Details> | |
| Birth Date: | | | Fax: <GP Details> | |
| Tel (Home): | | | NHS email *(for receipt of an electronic report*): **MANDATORY** | |
| Tel (Work): | | | *@* | |
| Tel (Mobile): (Preferable) | | | Date of Referral: <Today's date> | |
| Email Address: | | |  | |
| Gender: | | |  | |
| NHS Number: | | |  | |
| BMI: | | | Assistance Required: Yes  No | |
| Ethnicity: | | | Interpreter Required: Yes  No | |
| First Language: <Main spoken language> | | | Chaperone Required: Yes  No | |
| **Ultrasound Scan Request** (excludes referrals for cancer, breast, obstetric, imaging, chest, ophthalmology, superficial lumps in the neck, axilla/armpit, or children under 18 and Wheelchair bound patient)  Please tick type of ultrasound required | | | Clinical Condition / Symptoms and Clinical Indication (including relevant previous medical history): | |
| Abdomen (including abdominal aorta) | Female Pelvis | | **What question would you like this examination to answer? PLEASE STATE CLEARLY AS INADEQUATE INFORMATION MIGHT LEAD TO PATIENT DELAY** | |
| Renal Tract (KUB) | Bladder pre-/post- Micturition | |
| Scrotal | Groin/Abdominal Wall  (suspected hernia) | |
| MSK (No Necks)  (specify area) | Doppler- lower limb veins (DVT)  **L**  **R** | |
| Doppler- carotid arteries | Doppler- lower limb arteries  **L  R** | |
| **Preferred Clinic Location – North and East London** (Please tick one or more) | | | | |
| **Barking & Dagenham**  Barking Community Hospital  Porters Avenue Doctors' Surgery  Broad Street Health Centre | | **Havering**  Harold Wood GP Walk in Centre  Cranham Health Centre | | **Redbridge**  **Hainault Health Centre** |

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| Signature: Name: <GP Name> Date: <Today's date> |