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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> |