

# Request for Ultrasound Scan



Patient number:	
WLI number:	

Referrers are required to complete sections 1-4 accurately and legibly. Inadequately completed forms will not be accepted.

## 1 - Patient details - print or affix addressograph or label

Title:		Forename:		Surname:	
DOB:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Address:					
Postcode:		Tel (Home):		Mobile:	

### Patient Identification

For Kingsbridge  
Private Hospital use only.

I have confirmed the above patient's name, address and DOB. Signed:

Verified by patient:  If another/status:  Signed:

## 2 - Cautions (if none, tick here )

### Pregnancy:

Yes

No

Date of LMP:

### Infection Risk:

MRSA

Category 3

Other

### Other cautions:

Diabetes

Blind

Impaired cognitive function

Asthma

Mobility

Deaf

Bronchospasm

Allergies (please specify):

Other (please specify):

## 3 - Clinical details/notes. Please include provisional diagnosis or indication and indicate results of previous tests / imaging if applicable.

E.C.G. report:

Chest x-ray report:

Referrer (print name):		Signature:		Date:	
Address:				Post Code:	

Please send completed form by post, fax or email to:

Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.

T: +44 (0) 28 9073 5272 | F: +44 (0) 28 9024 9929 | E: imaging@3fivetwo.com

