

# Request for Urodynamics



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

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

## 2 - Clinical details/indications

Please include provisional diagnosis or indication

## 3 - History

Please provide relevant history including previous test results

## 4 - Consultant details

Consultant (print name):		Signature:		Date:	
Address:				Post Code:	
<input type="checkbox"/> Report only					
<input type="checkbox"/> Report and printout of results					
Send to:				Post Code:	

<b>For Kingsbridge Private Hospital admin use:</b>	<b>This patient is:</b>
	<input type="checkbox"/> Insured <input type="checkbox"/> Self funding <input type="checkbox"/> WLI <input type="checkbox"/> Employer <input type="checkbox"/> Occ Health/Screen
	Insurance company/trust: <input type="text"/>
	Policy Number: <input type="text"/> Authorisation number: <input type="text"/>

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.

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