

Request for Ultrasound



Patient ref 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)		Tel (Mobile)				

Patient Identification - For Kingsbridge Private Hospital use only.

I have confirmed the above patient's name, address and DOB.		Signed	
<input type="checkbox"/> Verified by patient	If another/status	Signed	

2. Cautions (if none, tick here)

Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of LMP:				
Infection Risk	<input type="checkbox"/> MRSA	<input type="checkbox"/> Category 3	<input type="checkbox"/> Other				
Other Cautions	<input type="checkbox"/> Blind	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Impaired cognitive function	<input type="checkbox"/> Asthma	<input type="checkbox"/> Deaf	<input type="checkbox"/> Mobility	<input type="checkbox"/> Bronchospasm
<input type="checkbox"/> Allergies (please specify)							
<input type="checkbox"/> Other (please specify)							

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

ECG Report

Chest x-ray report

Referrer (print name)		Signature		Date	
Address				Postcode	

Please send completed form by post or email to:

Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | E: imaging@kingsbridgehealthcaregroup.com | kingsbridgeprivatehospital.com

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