CuRx Health Limited

ULTRASOUND REFERRAL FORM

FOR NHS NET EMAIL OR E-FAX

Please send Referral via: FAX: 01612970677 - Email: curx.referral@nhs.net
Phone: 01612970670 - E-RS

Scan Urgency: Routine [ ] Urgent [ ]

Patient full name			Male: [ ] Female: [ ]
NHS Number:		D.O.B:	
Address:		Tel:	
Town :		Mobile:	
Post code:		Email:	

Primary Care Trust name		GP Practice Details:	
Referring GP Practice Number		Address:	
Referrer's Name:			
GP/GPSI Nurse/AHP:			
Clinical summary/ reason for request :		Postcode:	
		Tel:	
		Fax:	
		Email:	

Abdomen		Shoulder	Other
Pelvis		Elbow	
Urinary Tract (KUB):		Hand/Wrist	
KUB & Prostate:		Hip	
Transvaginal:		Knee	
Testes:		Ankle	
Lumps & Hernia:		Foot	

Special Requirements:			
Mobility assistance:		Sensory impairment:	
Interpreter Required	[ ]Yes No [ ]	If Yes, please specify language	
Any other relevant information concerning the patient			

Please note we are unable to accept ultrasound referrals for following categories:

Any request for 2 week wait investigations
Thyroid
Breast
UNDER 18 years old