

**Imaging Request**

**Non-obstetric Ultrasound**

Please email completed form to: healthshareltd.nwl.bookings@nhs.net

Phone: 0800 6524157 [www.healthshare.org.uk](http://www.healthshare.org.uk)

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| **Process:** | **All patients will be contacted by letter or telephone within 5 working days with an appointment**  **Patient booking telephone number: 0800 6524157 (open 8am-6pm Monday to Friday)**  Referral forms will only be accepted when emailed directly from the **referring GP’s or GP Practice’s generic NHSmail address. Incomplete referral forms will be returned to referrer.** |

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| **PATIENT** | | | | **REFERRER** | |
| **Name** |  | | | **Name** |  |
| **NHS Number** |  | | | **GMC / HPC / NMC no.** |  |
| Patient’s Address |  | | | Practice Name & Address |  |
| Home number |  | | | **National Practice Code** |  |
| Mobile number |  | | | Telephone |  |
| Work number |  | | | Email (NHS.net only) |  |
| Email |  | | |  |  |
| **Date of Birth** |  | Gender |  | Ethnicity : | |
| Physical/Communication difficulties?  Yes – Details:  Interpreter required?  Yes – Details/Language: | | | | Eligible for and requires Hospital Transport?  Yes  Mobility Issues (Needs assistance to transfer)?  Yes – Details: | |

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| **TO BE COMPLETED FOR ALL EXAMINATIONS:**  **CLINICAL INDICATIONS / QUESTION TO BE ANSWERED / PROVISIONAL DIAGNOSIS PLEASE ENSURE THAT YOU HAVE COMPLETED EVERYTHING REQUIRED**  **AND NOTE MANDATORY FIELDS.**  Please provide sufficient clinical information (including relevant past medical history, medication & previous investigations) to ensure the appropriate investigation can be performed  in accordance with the Royal College of Radiologists’ guidelines - <https://www.irefer.org.uk/> |
| * **Details (must include clinical question to be answered):** |
| Urgent? Yes / No **Allergies: Diabetes?** |
| Relevant notes / documentation attached?  Yes – Details: |
| **Date of request:** |

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| **ULTRASOUND EXAMINATION (18+ years)** | |
| **INVESTIGATION(S) REQUESTED** – *Select and give details for all required, including which site of body as appropriate* | |
| **Abdomen** (includes liver, gallbladder, CBD, pancreas, spleen, kidney, aorta, IVD) | |
| **Female Pelvis TA/TV** | **MSK** |
| **Testes / Scrotum / Groin** |  |
| **Renal Tract** (incl prostate if male) | **Groin/Hernia** |
| **Other** (please specify) |  |
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| **Exclusion Criteria**  Non NHS patients, Patients not registered with a GP, Children under the age of 18, Pregnancy or Obstetric scans, 2ww patients  Breast/ Chest / Axilla / Cardiac / Chest / Thyroid/ Neck/ Soft tissue lumps/ Ophthalmology ,U/S guided procedures / Patient requiring hoist to transfer / Patients exceeding 150KG | |