Welbeck

Welbeck Imaging Referral Form

Please complete all sections of the form. **By completing this form, you confirm you have the consent required to share this information.**

PATIENT DETAILS

Title:	Forename:	Surname:
MRN:		
Date of birth:		Gender: ☐ Male ☐ Female ☐ Other
Residential address:		Postcode:
Telephone:	Mobile:	Email:

PROCEDURE(S)

Please select modality:

- ☐ X-Ray
- ☐ DEXA
  - ☐ Bone mineral density ☐ Whole-body Composition
- ☐ CT
- ☐ Standing CT for foot & ankle
- ☐ MRI (If Cardiac, please select below)
  - ☐ CMR ☐ Cardiac Perfusion ☐ Aorta
- ☐ Ultrasound

For MRI scan please ensure patient has no contraindications (please fill below):

Pacemaker/Defibrillator	☐ Yes	☐ No
Aneurysm clips	☐ Yes	☐ No
Cochlear implants	☐ Yes	☐ No
Brain/Spinal Stimulators	☐ Yes	☐ No

Additional information

- ☐ Is the patient diabetic
- ☐ Known contrast allergy
- ☐ Known renal impairment. State latest eGFR/Creat and date of result (Attach blood results to referral):
- ☐ Previous Imaging available for comparison? If so, please state where Imaging was taken:

EXAM (please specify specific examination required):

CLINICAL DETAILS:

Examinations cannot be performed without enough clinical information (ionizing radiation medical exposure regulations 2017):

Preferred Radiologist:

REFERER DETAILS

Gp/referrer name :	Gp/referrer practice :
Gp/referrer contact number:	Gp/referrer email:

EXTRA REQUIRMENTS

Special equipment requirements:	Wheelchair access: ☐ Yes
Interpreter required: ☐ Yes, please confirm language:	
Other:	

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:

T: +44 (0)20 3653 2001
E: bookings.diagnostics@onewelbeck.com

A: Bookings, Welbeck Imaging & Diagnostics, 1 Welbeck Street London W1G0AR

Welbeck

Welbeck Imaging Referral Form

PAYMENT DETAILS (IF KNOWN)

TYPE: ☐ Self-funding ☐ Insured ☐ Embassy ☐ Other (please complete below sections as appropriate)		
Insurance company:	Membership no.	Authorisation code:
Embassy:	Letter of guarantee: ☐ Yes (please attach)	

DECLARATION & FORM SUBMISSION

☐ I authorise this patient to undergo the above order.			
Name:	Signed:	Date:	Professional Reg No:

Radiographer Use:
Ensure LMP, DOSE, RADIOGRAPHER INITIALS AND CONTRAST INFORMATION ARE RECORDED ON COMPUCARE

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:

T: +44 (0)20 3653 2001
E: bookings.diagnostics@onewelbeck.com

A: Bookings, Welbeck Imaging & Diagnostics, 1 Welbeck Street London W1G0AR