Diagnostic Ultrasound Request Form

Patient Details

Title _____ Surname _____

Forename _____

Address _____

_____

_____

_____ Postcode _____

Home Telephone _____

Mobile Number _____

Date of Birth _____ / _____ / _____

Referrer Details

Referring Physician _____

Referrer details are needed in order to return the report / communication purposes

Address _____

_____

_____

_____ Postcode _____

Telephone Number _____

E-mail _____

Examination Requested

Examination Type

General abdominal ☐ MSK / Soft Tissue ☐ Gynaecology ☐ Obstetric ultrasound ☐ Lumps & Bumps ☐

Tick appropriate box

Please note a transvaginal examination may be performed with female pelvic scans where clinically indicated and there are no known / informed contraindications.

Clinical History / Relevant Test Results:

Examination Required:

Is the patient ambulant Yes ☐ No ☐

Patient Weight = _____ BMI = _____ *(Unfortunately we are unable to scan patients with a weight exceeding 170Kg)*

Does the patient require an interpreter Yes ☐ No ☐ *(Interpretation services will be the responsibility of the patient if required)*

Diabetic Status / Any special requirements: _____

Date of referral: _____ / _____ / _____ **Referrer Signature** _____

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