UME GROUP DIAGNOSTICS

BOOKINGS: 0800 222 9048 EMAIL: client.support@umegroup.com

Imaging Referral Form

Coventry Fax 02476 604 526 *Harley Street Fax 0844 567 8218*

Patient details (affix label if available)

Title Other	Address
First name	
Surname	Postcode
DOB Male ◯ Female ◯	Self pay ◯ Insured ◯ NHS ◯ Third party ◯
Contact telephone number(s):	Insurance Co
Mobility: Mobile ◯ Non-mobile ◯	Policy number

Examination/Procedure

CT ◯ X-ray ◯ Ultrasound ◯

	Routine ◯ Urgent ◯
	Date of follow up appointment:

Relevant clinical details

CT contrast investigations: In line with Royal College of Radiologists guidelines a recent (in the last three months) serum creatinine level or eGFR must be available prior to imaging.

Serum creatinine/eGFR reading: Date taken:

Referring clinician's details (stamp or affix label if available)

Referrer name:

GMC number:

Contact Tel No:

Signature of Referring clinician :

Please indicate how you would like to receive the results of the investigation?

◯ **By Post** - Postal Address:

◯ **By Fax** - Fax Number:

◯ **By Email** - Email Address:

CD of images will be given to the patient. Do you wish to receive a copy? ◯ Yes ◯ No

Further copies of this form are available to download at www.umediagnostics.com

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