|  |  |
| --- | --- |
|  | **Referral for Ultrasound Scanning****Telephone: 0161 503 6205****Email to: Referrals.harmonicsonography@nhs.net** |
| **ALL FIELDS ARE MANDATORY****ANY FIELDS NOT COMPLETED MAY RESULT IN THE REFERRAL BEING****DELAYED, RETURNED AND/OR REJECTED** |
| **GP PRACTICE CODE:** |  | **CCG:** |  |
| **Patient Details** | **Referring Clinician Details** |
| **Name** |  | **Name** |  |
| **DOB** |  | **Address** |  |
| **Gender** |  |
| **Address** |  |
| **NHS No** |  | **Postcode** |  |
| **E-mail** |  | **Telephone** |  |
| **Telephone** |  | **E-mail** |  |
| **Mobile** |  |  |  |
| **SCANNING REQUEST:** | **[ ]  ROUTINE [ ]  URGENT** | **PREVIOUS IMAGING ATTACHED** [ ]  |
| **[ ]  Abdomen** | **[ ]  Urinary Tracts** | **[ ]  Gynaecological** | **[ ]  Musculoskeletal** | **[ ]  Soft Tissue** |
| **[ ]  Vascular** | **[ ]  Scrotum** | **[ ]  Thyroid** | **[ ]  Salivary Glands** | **[ ]  Abdominal Wall** |
| **[ ]  Groin** | **[ ]  Other** | **SPECIFY:** | **[ ]  RIGHT** |
| **[ ]  LEFT** |
| **Clinical information** (include symptoms, history, medication and allergies)**:** |
| **Special requirements:** Mobility assistance [ ]  Sensory impairment [ ]  Translator required? Yes [ ]  No [ ]  Language: Transport required (if eligible)? Yes [ ]  No [ ]  Diabetic Yes [ ]  No [ ]  Other:  |
| **Referrer’s Signature:** |  | **Date:** |  |
| **Job Title:** |  | **Professional Registration Number:** |  |