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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | **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:** | | | | | |  | |