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 ☐ Language: ____________________

Transport required (if eligible)? ☐ Diabetic ☐ Other requirements: ____________________

Referrer's Signature:		Date:	
Job Title:		Professional Registration Number:	