Spire
Wellesley Hospital

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Southend On Sea
Essex
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Wellesleyimagingdepartment@spirehealthcare.com

IMAGING REFERRAL FORM

Appt:

Title Surname

Unit No. Episode No.

First name

Examination required

Address / Room No. **IP** **OP**

Postcode

Specific Radiologist required

Referring clinician

Telephone number(s)
Home

Work

Male ☐ Female ☐ DOB / /

Clinical information

LMP DATE
OR PATIENT NOT PREGNANT ☐

Additional information

Address for report / films

PLEASE TICK:

PRIVATE PATIENT ☐

SELF-FUNDING ☐

NHS ☐

Referrer's Signature

Date / /

FOR HOSPITAL USE

No. of films	No. of exp	Fluoro time/ factors	Radiographer	Date	Equipment

6 Point ID Completion	Please Tick Accordingly
Name	
D.O.B	
Address	
Reason for Attending	
Side of interest	
Previous Imaging	
Radiographer Signature	

REFERRER'S DECLARATION

1. The correct patient details have been entered.
2. I have discussed this examination with the patient/guardian.
3. I have taken into account the possibility of pregnancy.
4. I have given sufficient clinical information for the request to be justified according to IR(ME)R.
5. I will ensure that the examination result is recorded in the patient's case notes.