Spire
Little Aston Hospital

# Imaging referral

Appt:

Title Surname

Unit No. Episode No.

First names

Examination required

Address

Postcode

Clinical information

Telephone number

Home

Mobile

Male ☐ Female ☐ Date of birth

Specific radiologist required

LMP date

To the best of my knowledge I am not pregnant

Sign Date

Referring clinician

Additional information

Address for report / films

Signature Date

**FOR HOSPITAL USE**

| No. of films | No. of exp | Fluoro time/ factors | Dose Gy/cm3 | Radiographer | Date | Equipment |
|---|---|---|---|---|---|---|
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| Drug | Amount | Batch No. | Administered by |
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| Sim code | Area | Quanity | Price | Radiologist | Posted by |
|---|---|---|---|---|---|
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Forms can be sent by email to **spire.littleaston-radiology@nhs.net** or a referral can be submitted online at Spire Connect via **https://spireconnect.spirehealthcare.com**. Please call **0121 580 7129** if you have any queries.