



**Spire**  
South Bank Hospital

139 Bath Road  
Worcester  
WR5 3YB

Tel 0190 536 2223  
Fax 0190 535 7280

# Imaging Referral

Appt:

Unit No.  Episode No.

Examination required

Clinical information

Specific radiologist required

Referring clinician

Address for report / films

Signature

Date  /  /

Title  Surname

First Names

Address / Room No.  IP  OP

Postcode

Telephone number(s)

Home  Work

Male  Female  Date of birth

LMP Date

OR

Sign  Date  /  /

*To the best of my knowledge I am not pregnant*

Additional Information

**FOR HOSPITAL USE**

No. of films	No. of exp.	Fluoro time / factors	Dose Gy / cm <sup>2</sup>	Radiographer	Date	Equipment
Drug		Amount	Batch No.		Administered by	
Sim code		Area	Quantity	Price	Radiologist	Posted by