IMAGING REFERRAL

The Montefiore Hospital
2 Montefiore Road
Hove
BN3 1RD

Tel: 01273 828088 email: montefiorediagnostics@spirehealthcare.com

<table>
<tr><td colspan="3">Insurance provider:
Policy number:
Authorisation code (if any):</td><td>Self-Pay:</td><td colspan="2">Other:</td></tr>
<tr><td colspan="6">To comply with IR(ME)R regulations and local policy please complete all sections accurately below this line. Incomplete or unsigned forms will be returned to the referrer. Please use patient label wherever possible.</td></tr>
<tr><td colspan="3" rowspan="5">SAP Number:

Surname: Title:

Forename:

Address:</td><td>Date of Birth:</td><td colspan="2"></td></tr>
<tr><td>Gender:</td><td colspan="2"></td></tr>
<tr><td>Telephone Number/s:</td><td colspan="2"></td></tr>
<tr><td colspan="3">LMP date:</td></tr>
<tr><td colspan="3">OR
Patient signature:
Date:
To the best of my knowledge I am not pregnant</td></tr>
<tr><td rowspan="2">Examination Requested (please specify)</td><td colspan="2">MRI</td><td colspan="3">Ultrasound</td></tr>
<tr><td colspan="2">CT</td><td colspan="3">X-Ray/Fluoroscopy/Mammography</td></tr>
<tr><td>Clinical Information</td><td colspan="5"></td></tr>
<tr><td colspan="2">Referred by:</td><td colspan="2">Signature:</td><td colspan="2">Date:</td></tr>
<tr><td>Referred to:</td><td>SPRING</td><td colspan="2">ICON</td><td colspan="2">SIP</td></tr>
<tr><td colspan="6">Preferred radiologist/cardiologist (if any):</td></tr>
<tr><td colspan="6"><u>Diagnostics use only:</u></td></tr>
<tr><td>Area for imaging:</td><td colspan="2"></td><td>Preparation required:</td><td colspan="2"></td></tr>
<tr><td>Imaging time required:</td><td colspan="2"></td><td>Other information:</td><td colspan="2"></td></tr>
<tr><td>Appointment time:</td><td colspan="2"></td><td>Appointment date:</td><td colspan="2"></td></tr>
<tr><td>Dose/ Screening time:</td><td colspan="2"></td><td>Drugs/contrast used:</td><td colspan="2"></td></tr>
</table>