

Harrogate Clinic  
Gardner House  
Hornbeam Park Avenue  
Harrogate  
HG2 8NA

Appt:

**Imaging Referral**

The completed form is to be filled in electronically and emailed via the following link: [harrogateclinicradiology@spirehealthcare.com](mailto:harrogateclinicradiology@spirehealthcare.com?subject=Imaging%20Referral)

Unit No: Click or tap here to enter text.

Title: Click or tap here to enter text.

Surname: Click or tap here to enter text.

First names: Click or tap here to enter text.

Episode No: Click or tap here to enter text.

Examination required:

Click or tap here to enter text.

Address/Room No (incl. Postcode):  
 Click or tap here to enter text.

Clinical information:

Click or tap here to enter text.

Telephone number(s):

Home: Click or tap here to enter text.

Work: Click or tap here to enter text.

Gender assigned at birth:

Male  Female  Date of birth: Click or tap to enter a date.

Patient preference: Click or tap here to enter text.

Specific radiologist required:  
Click or tap here to enter text.

LMP Date: Click or tap to enter a date.

Referring clinical:   
Click or tap here to enter text.

**OR**

Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_/\_\_\_

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

Address for report/film(s):

Click or tap here to enter text.

Additional information: Click or tap here to enter text.

Signature:

Date: Click or tap to enter a date.

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| **FOR HOSPITAL USE** | | | | | | | | | | | | | | |
| **No. of films** | | **No. of exp.** | **Fluoro time/factors** | | | **Dose Gy/cm2** | | | **Radiographer** | | **Date** | | | **Equipment** |
|  | |  |  | | |  | | |  | |  | | |  |
| **Drug** | | | | **Amount** | | | **Batch No.** | | | | | **Administered by** | | |
|  | | | |  | | |  | | | | |  | | |
|  | | | |  | | |  | | | | |  | | |
| **Sim code** | **Area** | | | | **Quantity** | | | **Price** | | **Radiologist** | | | **Posted by** | |
|  |  | | | |  | | |  | |  | | |  | |
|  |  | | | |  | | |  | |  | | |  | |