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| **trinity logo.png** | **NUCLEAR MEDICINE REFERRAL FORM** | **TMI House,** **29 Waverley Way,****Carshalton Beeches, SM5 3LQ** |

**Please complete all fields in black ink:**

|  |
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| **REFERRER’S DETAILS** |
| **Title** |  | **Forenames** |  | **Surname** |  |
| **Practice or Clinic Name** |  | **Send images to this PACS?** |[ ]
| **Address** |  |
| **Mobile No.** |  | **Bleep**  |  |
| **Email address** |  |
| **How do you want report sent to you?** | Choose email/fax/post | **Email address or** **fax number**  |  |
| **PATIENT DETAILS** |
| **Tick Referral Category** | NHS |[ ]  Private Insured |[ ]  Private Self-Pay |[ ]  Cat II |[ ]
| **NHS /Hospital Number** |  | **Date of Birth** | enter a date. |
| **Title** |  | **Forenames** |  | **Surname** |  |
| **Address** |  |
| **Telephone No.** |  |
| **Email address** |  |
| **EXAMINATION REQUIRED** |
| **Scan Required** |  |
| **Relevant Clinical Details** |  |
| **Is the patient?** | Pregnant |[ ]  Breastfeeding |[ ]  Weigh >120kg |[ ]  Disabled |[ ]
| **Does the patient need?** | Hoist |[ ]  Interpreter |[ ]  Carer |[ ]  Oxygen |[ ]
| **Please provide details** |  | Allergies |[ ]
| **GP DETAILS** |
| **GP Name** |  |
| **Practice or Clinic Name** |  |
| **Address** |  |

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| **Completed form should be sent by email or fax.** |
| Email to **referrals@trinitymedicalimaging.co.uk** |
| Fax **020 3137 2156**  | Call **020 3137 2155 for enquiries** |