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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:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | |  | | | | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **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** |