HARLEY STREET MEDICAL CENTRE

27 Harley Street, London W1G 9QP

Telephone: 0207 467 6190
Email: client.support@umegroup.com

Imaging Referral Form

Patient details (affix label if available)

Title Other	Address:
First name:	
Surname:	Postcode:
DOB: Male ◯ Female ◯	Self pay ◯ Insured ◯ NHS ◯ Third party ◯
Contact telephone number(s):	Insurance Company:
	Policy Number:
Mobility: Mobile ◯ Non-mobile ◯	Authorisation Code:

Examination/Procedure

CT ◯ X-ray ◯ Ultrasound ◯

	Routine ◯ Urgent ◯
	Date of follow up appointment:

Relevant clinical details

Any chance of pregnancy ◯ Yes ◯ No Signature .....

CT contrast investigations: In line with Royal College of Radiologists guidelines a recent (in the last three months) serum creatinine level or eGFR must be available prior to imaging.

Serum creatinine/eGFR reading: Date taken:

Referring clinician's details (stamp or affix label if available)

Referrer name:

GMC number:

Contact Tel No:

Signature of referring clinician :

Please indicate how you would like to receive the results of the investigation?

◯ **By Encrypted Email** - Email Address:

◯ **By Post** - Postal Address:

CD of images will be given to the patient. Do you wish to receive a copy? ◯ Yes ◯ No

Further copies of this form are available to download at www.harleystreet-medicalcentre.com

AVIVA · AXA PPP HEALTHCARE redefining / standards · Bupa · Cigna · healix HEALTH SERVICES · simplyhealth · VitalityHealth · WPA