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| **Radiology Referral: over 16 years old** | A4 Minutes background Mono v4Radiology use only  Previous imaging: | **A4 Minutes background Mono v4** |
| Name:  DOB:  NHS/UR No:  Address:  M / F  **Tel/Mob. No:** |
| Clinical indications **and** questions to be answered:  Examination / area of interest:  DATE: | |
| ESSENTIAL BOOKING INFORMATION:  Chair:  Transport:  Hoist:  Infection Risk: Y / N |
| GP/Surgery: | Pregnancy Status: Y / N  LMP: | |
| **Referral Location:** | NHS | Private |
| **Signature: authorised referrer IR(ME)R 2017:** | **Name Printed:** | |
| Job Title: | Contact number: | |
| **Important Information** |  | |
| **RADIOLOGY BOOKED APPOINTMENT SERVICE**  \*GP’s: Please email all referral forms to:  [shft.radoffice@nhs.net](mailto:shft.radoffice@nhs.net)  **48 hours** following their GP referral  The Patient is to call: **01590 663110**  to book their X-ray appointment between  **10am & 3pm, Monday to Friday.**  For URGENT referrals, please indicate on the referral form.  An appointment will be booked for the patient.  **FORM VALID FOR 1 MONTH ONLY** | **Site Opening times:**  **Lymington:** Monday-Friday:  08.45-12.30 and 13.30-16.00  **Romsey:** Tuesday, Thursday & Friday:  08.45-12.30and13.30-16.00  **(No transport or hoist patient access)**  **Hythe: Booked appointment – Closed until further notice.**  **\*Patients Please Note: DO NOT bring children to your appointment. We are unable to supervise during your examination.** | |
| INCOMPLETE/ILLEGIBLE FORMS WILL BE RETURNED | | |