|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Contact Details for the services | | | | | | | | | | | | |
| Email | | [radoffice@southernhealth.nhs.uk](mailto:radoffice@southernhealth.nhs.uk) - **All referrals must be emailed** | | | | | | | | | | |
| Address | | Radiology, LNFH, Wellworthy Rd, Lymington, Hants, SO41 8QD | | | | | | | | | | |
| Telephone | | X-ray – 01590 663110 - MRI/CT – 01590 663125 - Ultrasound – 01590 663120 | | | | | | | | | | |
| **RADIOLOGY WILL CONTACT THE PATIENT WITH DETAILS OF THEIR APPOINTMENT** | | | | | | | | | | | | |
| Patient’s details | | | | | | | Patient’s background and culture | | | | | |
| Name | Full Name | | | | | | Ethnicity | | Ethnic Origin | | | |
|  |  | | | | | | 1st language | | Main Language | | | |
| DOB | Date of Birth | | | Age | Age | | Interpreter required? Interpreter required | | | | | |
| Sex | Gender(full) | | | | | | Military Veteran? | | | | | |
| Address & postcode | Home Full Address (stacked) | | | | | | Referrer details | | | | | |
|  |  | | | | | | Referring Clinician | |  | | | |
|  |  | | | | | | Address | | Organisation Name  Organisation Full Address (stacked) | | | |
| NHS No | NHS Number | | | | | | Tel no | | Organisation Telephone Number | | | |
| Hospital No | Hospital Number | | | | | | Email | | Organisation E-mail Address | | | |
| Home tel | Patient Home Telephone | | | | | | Referral date | | Short date letter merged | | | |
| Work tel | Patient Work Telephone | | | | | | Date received | |  | | | |
| Mobile tel | Patient Mobile Telephone | | | | | |  | |  | | | |
| Email | Patient E-mail Address | | | | | |  | |  | | | |
| Preferred contact method | | | Home | | |  | Work |  | Mobile |  | E-mail |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Social Information** | | | | | | |
| Social Context | Has a Carer | | Is a Carer | | Lives Alone |  |
| Transport Issues | Chair: | | Transport required: | | | Hoist required: |
| Next of Kin |  | | | | | |
| Relationship to Patient |  | | | | Telephone No |  |
| Infection Risk |  | | | | | |
| Smoking History |  | | | | | |
| Pregnancy Status | Pregnant | Y / N | | LMP: | | |

|  |  |
| --- | --- |
| **Reason for referral** | |
| **C**linical Indications and questions to be answered: | |
| Examination / Area of interest | |
| Signature: authorised referrer IR(ME)R 2017: | Printed Name: |
| Job Title: | Contact Number: |

**Important information**

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| **RADIOLOGY BOOKED APPOINTMENT SERVICE**  For **URGENT** referrals, please indicate on the referral form and we will contact the patient directly.  **FORM VALID FOR 1 MONTH ONLY** | **Sites:**  **X-ray**- Lymington and Romsey  **Ultrasound**- Lymington Romsey and Hythe    **No transport or hoist patient access at Romsey or Hythe**  **\*Please Note: DO NOT bring children to Radiology appointments. We are unable to supervise during examination.** |
| **INCOMPLETE / ILLEGIBLE FORMS WILL BE RETURNED** | |