first contact health

SCANNING + DIAGNOSIS + TREATMENT

CT Extremity Scanning Referral Form

Patient Details			
Title		Funding Details	
First Name		Self Funding	☐
Surname		Insured	☐
Date of birth		Insurer:	
Telephone			
Email Address		Policy Number:	
Address			
		Office use - Auth Code	
Postcode			

Clinical history and presentation:

Clinical question to be answered:

Region/s to be scanned:	Specific area/s of interest:

Is an Arthrogram required? Yes: ◯ No: ◯

Safety check		
If YES to following, please phone to discuss - it is the expectation that scanning will be unable to proceed		
Is the patient currently/could the patient currently be pregnant?	Yes: ◯	No: ◯
Has it been in excess of 28 days since the patient's LMP?	Yes: ◯	No: ◯
If yes to the above: what was the date of the patient's LMP?		

I confirm I wish to undergo an XR examination despite being over 28 days since my last menstrual period (must be signed by hand)

Name		Date		Signature	

Referrer Details			
Title		Signature	
Name			
Speciality			
Practice address		Date:	
		Send report by:	
Telephone		Email:	☐
Email Address		Post:	☐
Fax		Fax:	☐

Click here to submit form - or send to Imaging.Guernsey@FirstContactHealth.com

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