COYNE
MEDICAL

Ultrasound Scan Request Form

Patient details

Patient name	Date of birth
Patient Hospital No:	Referrer Name (Printed):
Patient address	Practice Name/Hospital Name/Ward
Telephone/Mobile Number:	Specific Radiologist Request:
Examination(s) requested:	
Clinical Indication/Reason for request:	
Referrer's Signature:	Date:

PLEASE READ BEFORE SENDING

A COMPLETED REQUEST FORM WILL BE REGARDED AS A REQUEST FOR AN OPINION FROM COYNE MEDICAL TO ASSIST IN THE CLINICAL MANAGEMENT OF A PATIENT. REQUESTS MUST BE SIGNED AND DATED BY A REGISTERED MEDICAL PRACTITIONER OR OTHER REGISTERED HEALTH PROFESSIONAL.

A COMPLETED FORM MUST PRECEDE OR ACCOMPANY THE PATIENT. DIGITAL COPIES ARE ACCEPTED.

PLEASE MARK THE FORM CLEARLY WITH THE REFERRERS CONTACT DETAILS.

PLEASE ENSURE THE FORM IS CLEAR AND LEGIBLE AND HAS ADEQUATE CLINICAL INFORMATION TO JUSTIFY THE EXAMINATION BASED ON THE ROYAL COLLEGE OF RADIOLOGIST'S GUIDELINES.

UNDER THE IR(ME)R, ALL IMAGING REQUESTS MUST BE JUSTIFIED BY AN ULTRASOUND PRACTITIONER TO ENSURE THAT THERE IS A NET BENEFIT FROM THE EXAMINATION TO THE PATIENT. REQUESTS THAT ARE ILLEGIBLE, UNSIGNED, OR LACK THE REQUIRED INFORMATION WILL BE RETURNED.

REQUESTS CAN BE SENT BY EMAIL, FAX, OR POST USING THE CONTACT DETAILS BELOW:

T: 020 7731 3077 F: 020 3793 0207

660 Fulham Rd, London, SW6 5BT

contact@coynemedical.com

www.coynemedical.com