DIRECT MEDICAL IMAGING Tel: 01253 640000 Fax: 01253 720027 **ULTRASOUND REQUEST**

Surname Mr/Mrs/Miss	Referrer		Radiology Use	Attendance Number
Forename (s)	Justified by	Practitioner		Date of Examination
Address				(Office Use Only)
	Telephone		Radiographer / Operator	
Postcode	Date of Birth / /			Diabetic Yes/No

Clinical details. Please state the problem:

Doctor's Signature

Previous Operations	Results required for:-	Appointment
Examination Requested	Referrer's Signature	Day
		Date
Date Received	Date of Request / /	Time