Imaging Request Form

Peregrine Road, Westhill Business Park,
Aberdeenshire AB32 6JL
Appointments Tel: 01224 515254
Email: imaging@rochealthservices.com
Website: rocprivateclinic.com

ROC PRIVATE® CLINIC

Patient Details	
Name: _____ Date of Birth: _____ Address: _____ _____ _____Postcode: _____ Landline/Mobile: _____ Email: _____ Preferred method of contact: Phone ☐ Email ☐	**Funding** Self-Funded ☐ UK Insurance ☐ Int. Insurance ☐ NHS ☐ Patient's Insurance Company: _____ Membership Number: _____ Pre-authorisation Number: _____ Please note: Uninsured patients and insured patients without pre-authorisation are required to pay on the day of their appointment

Referral Information	**Clinical Indication for Referral**
X-ray / Ultrasound Region to be imaged:	
For X-ray only - date of last menstrual period:	

Previous Medical History
Please provide details of any previous, relevant medical history including surgery: Please include any recent imaging reports.

Safety Check	**ROC Staff Use**
Could the patient be pregnant? Yes / No Is the patient breastfeeding? Yes / No Is the patient a high infection risk? Yes / No If yes, please specify: Does the patient have any allergies? Yes / No If yes, please specify:	Justified by: Name: _____ Signature: _____ Date: _____

Referring Clinician	
Name: Signature: Date: IR(ME)R 2000 regulations require referrals to be signed by referring clinician	Address: _____ _____ _____ Postcode: _____ Landline/Mobile: _____ Email: _____ Preferred method of contact: Phone ☐ Email ☐