Imaging Request Form
Echocardiogram

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

Patient Details	**Funding**
Name: _____ Date of Birth: _____ Address: _____ _____ _____Postcode: _____ Landline / Mobile: _____ Email: _____ Preferred method of contact: Phone ☐ Email ☐	Self-Funded ☐ UK Insurance ☐ Int. Insurance ☐ NHS ☐ Patient's Insurance Company: _____ Membership Number: _____ Pre-authorisation Number: _____ Please note: Uninsured patients and insured patients without preauthorisation are required to pay on the day of their appointment
Referral Information	**Previous Medical History**
Region to be imaged:	Please provide details of any previous, relevant medical history including surgery: Please include any recent imaging reports.
Clinical Indication for Referral	
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	**Clinician Contact Details**
Name: Signature: Date: GMC Number SOR and BMUS guidelines require referrals to be signed by referring clinician**. Referrers must provide accurate patient demographics and clinical information. Referral criteria are described in the RCR booklet 'Making best use of clinical radiology services' (latest edition), available online as iRefer at: https://www.irefer.org.uk/guidelines**	Address: _____ _____ _____ Postcode: _____ Landline / Mobile: _____ Email: _____ Preferred method of contact: Phone ☐ Email ☐