

Patient Details Name: _____ Date of Birth: _____ Address: _____ _____ _____ Postcode: _____ Landline / Mobile: _____ Email: _____ Preferred method of contact: Phone <input type="checkbox"/> Email <input type="checkbox"/>	Funding Self-Funded <input type="checkbox"/> UK Insurance <input type="checkbox"/> Int. Insurance <input type="checkbox"/> NHS <input type="checkbox"/> 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 X-Ray Region to be imaged: _____	Previous Medical History Please provide details of any previous, relevant medical history including surgery: Please include any recent imaging reports.
Clinical Indication for Referral 	
Safety Check 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:	ROC Staff Use Justified by: Name: _____ Signature: _____ Date: _____
Referring Clinician Name: _____ Signature: _____ GMC No: _____ Date: _____ IR(ME)R 2017 – ROC Private Clinic entitles General practitioners and hospital consultants as referrers for all X-ray examinations. 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	Clinician Contact Details Address: _____ _____ _____ Postcode: _____ Landline / Mobile: _____ Email: _____ Preferred method of contact: Phone <input type="checkbox"/> Email <input type="checkbox"/>