DIAGNOSTIC IMAGING REFERRAL

THE MONTEFIORE HOSPITAL
Part of Spire Healthcare

The Montefiore Hospital
2 Montefiore Road
Hove
BN3 1RD
Tel: 01273 828 088 Fax: 01273 828 155 email: montefiorediagnostics@spirehealthcare.com

Patient details:			
Name: **Address:** **Postcode:** **Is the patient insured or self-funding?**		**Date of Birth:**	
		Gender:	
		Telephone Number/s:	
		LMP date:	
		OR **Patient signature:** **Date:** **To the best of my knowledge I am not pregnant**	
Examination Requested (please specify and include area to scan)	**MRI**	**Ultrasound**	
	X-Ray	**Fluoroscopy**	
Clinical Information			

Referring GP details:			
GP name: **Practice address:** **Postcode:**			
GP Signature:		**Date:**	
Preferred radiologist (if any):			
To comply with IR(ME)R regulations and local policy please complete all sections above this line. Failure to do so may result in delays.			
Diagnostics use only:			
Area for imaging:		*Preparation required:*	
Imaging time required:		*Other information:*	
Appointment time:		*Appointment date:*	
Dose/ Screening time:		*Drugs/contrast used:*	