ULTRASOUND REFERRAL FORM

Murakami MEDICAL CENTRE

Please fax or e-mail this form to Murakami Medical Centre.
email: info@murakamimedicalcentre.co.uk
fax: 020 3876 6876 tel: 020 8961 1117

PATIENT'S DETAIL

Forename:

Surname:

Address:

DOB: Gender: Male Female Other

Contact N:

Email:

Ethnicity:

If interpreter required, language:

Presenting complaint & provisional diagnosis

Please provide as much relevant clinical information as possible to assist with the interpretation of the referral and images.

GENERAL ULTRASOUND CLINIC

Abdomen		Testes	
Abdomen & Pelvis		Breast	
Urinary/ Renal Tract/KUB		Thyroid	

SPECIALIST CLINIC

Suspected hernia:	
Prostate	
Salivary glands	
Soft Tissue - Lymph node/ Lump and Bump/ Others	

PREGNANCY CLINIC

Early reassurance/ viability scan	
NT/ Dating Scan	
NIPT Non- Invasive Pre-Natal Testing	
Gender Scan	
Detailed Anatomy Scan	
Fetal Wellbeing Scan	

REFERRER'S DETAIL

Name:

GMC/ HPC:

Address:

Ref. Practice:

Contact n:

Email:

Signature: _____ Date: ____/ ____/ _____