



Cornwall House

Sandy Lane  
Newcastle-under-Lyme  
Staffordshire  
ST5 0LZ

T: 01782 338100

F: 01782 714609

E: [cornwall.house@inhealthgroup.com](mailto:cornwall.house@inhealthgroup.com)

# Patient Referral Form

## WARNING

Cardiac pacemakers, Cerebral aneurysm clips and Metallic foreign bodies in the eye are **ABSOLUTE CONTRA-INDICATIONS** for MRI.

MRI  X-Ray  DXA  Ultrasound  Mammogram

### Patient Details

Hospital No: \_\_\_\_\_

Full name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Daytime Telephone: \_\_\_\_\_

Evening Telephone: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_\_\_ Male  Female

### Referring Consultant

Name: \_\_\_\_\_

Address for films and report: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Clinician registration number: \_\_\_\_\_

Category: Self-funded  Insurance  Is there a possibility of Pregnancy? Yes  No

### Preferred Consultant Radiologist:

### Examination Requested

Urgent  Routine

Area(s) to be examined/scanned: \_\_\_\_\_

Clinical Details:

Previous Surgery (please specify): \_\_\_\_\_

Previous Imaging (please specify): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_/\_\_/\_\_\_\_

PRINT NAME: \_\_\_\_\_

Please send this referral form to [cornwall.house@inhealthgroup.com](mailto:cornwall.house@inhealthgroup.com)

Ref No. UnitDMOct10