**Direct access non-obstetric ultrasound request form**

**Patient details**

**Surname:**

**First Name:**

**D.O.B. / /**

**NHS no:**

**Address:**

**Tel No.:**

**Mobile No:**

**GP details**

**Name:**

**GMC No:**

**Practice Code:**

**Surgery:**

**Tel:**

**E-mail:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Ultrasound Scan Request** (please select scan(s) required) | | | |
| **Abdomen** |  | |  |  | | --- | --- | | Diabetic | Y N | | Interpreter  required | Y N | | Severely impaired mobility | Y N |   **CLINICAL INFORMATION**  Relevant history, examination, investigations  What information do you require from this examination? | |
| **Renal Tract** |  |
| **Pelvis** (male or female) |  |
| **Ovarian investigation (this is NOT 2ww)** |  |
| **Aorta** |  |
| **Scrotum** |  |
| **Musculoskeletal** |  |
| **Superficial mass**  NOT neck/groin/axilla |  |
| **Neck** |  |
| **Groin** |  |
| **Vascular** |  |
| **Other** (please specify)  **NOT AXILLA/BREAST – see below** |  |
| **(please circle)**  **OVARIAN**  **URGENT**  **ROUTINE** | | Has previous imaging (X-ray/US/CT/MRI) been performed for the same problem? (please specify above) | Y N |
| Signature | | Name Printed | Date |

**Please note this form must not be used for axilla / breast ultrasound requests.** These require a referral letter to the RMS under the breast surgery speciality as urgent.

Please refer to the RMS website for more detailed information regarding ultrasound scans.

**Ovarian investigation** is a 3-4 week wait; please only use this if referral meets criteria.