HSU Clinical & Rehabilitation Services

PLEASE INCLUDE ALL PATIENT AND REFERRER DATA REQUESTED

X –ray request form - external referrer

Please complete this form and send via egress to: xrayreferrals@aecc.ac.uk
Appointments: 01202 436503
Parkwood Campus, Parkwood Road, Bournemouth, Dorset, BH5 2DF

Date of request		File Number:

Patient data

Name	D.o.B	Gender M ☐ F ☐
Address Postcode Contact number		Is this the same as the patient's birth gender?

Area(s) required	Views

Any relevant previous imaging (past year)?		If yes please complete below:		
Y ☐	N ☐	Date / /	Type (i.e. x-ray, ultrasound, CT, MRI)	Where taken

Clinical justification (please write clearly.)	Include relevant clinical symptoms such as onset, type, location, level. Any history of trauma including the date(s). Any history of malignancy including dates and type. Please also include how the results of the x-ray will influence your clinical management. What is your clinical diagnosis that you would like X-Ray to confirm or deny?

Referrer Data

I confirm that I am a registered referrer with Health Sciences University and as such have provided evidence of IR(ME)R training. Referrers signature Print name Professional registration number	Referrers Profession Practice address and telephone number 1st Email Address
*** To opt in to receive a copy of the images via IEP (Image Exchange Portal) - please include your email address plus a mobile phone number or second email address:	Mobile phone number, or 2nd email address