REFERRAL LETTER FOR ULTRASOUND TRIMESTER DATING

Scan Required +/- T.V. as indicated

COMPLETE ALL SECTIONS IN BLOCK CAPITALS

Referrer Details: Name: …… IMC No ……

Address: ……

Contact Phone Number ……

Email ……

Patients Details:

Name: …… DOB ……

Address: ……

Tel No …… Email ……

Clinical Indication

Obstetric history (Previous Pregnancies/Ectopic/ C Section):
……

……

LMP Date/Gestation/Length of Menstrual Cycle (if known)
……

Relevant Medical /Surgical history (Diabetic etc) ……

……

Allergies (including Latex) ……

Date and Time of Consultation: ……

Signature of Referrer ……

Patient Information Leaflet Given YES NO

All fields MUST be completed in full in order to schedule an appointment. Failure to do so could result in delays in making an appointment.

Referral letter to be sent to: ultrasoundsupport@affidea.com by HEALTHMAIL ONLY