PALL MALL MEDICAL
Excellence in Private Healthcare and Aesthetics

Radiology & Imaging Patient Referral Form

Free fax: 0800 471 5205 • Email: admin@pallmallmedical.co.uk • Call: 01744 62 44 64

Patient Details

First Name:		**Surname:**	
Date of Birth:		**Sex:**	**Male** ☐ **Female** ☐
Postcode:		**House Number:**	

Payment Information

Practice paying ☐	**Patient self-paying** ☐	**Patient's Medical Insurance** ☐	
Invoice will be sent directly to practice, payable within 30 days upon receipt of invoice	*Invoice will be sent directly to patient, payable upon receipt of email before the appointment takes place*	*Insurance company:*	
		Authorisation code:	
Medico Legal ☐	**(relevant details to be requested by Provider)**		

Booking Information

Book appointment via Practice ☐		**Book appointment via patient** ☐	
PMM will contact the practice directly to book the appointment		*PMM will contact the patient directly to book the appointment*	
Representative email address:		**Patient email address:**	
Representative phone number:		**Patient phone number:**	

1. Imaging / Diagnostics Referral Type

Modality:	**MRI** ☐ **CT** ☐ **X-Ray** ☐ **Ultrasound** ☐ **Other** ☐**:**
Contrast:	**Yes** ☐ **No** ☐

2. Clinical Information – *please provide as much information as possible here for the clinician to review and provide an accurate & meaningful diagnosis. Illegible writing may cause delays to the process.*

3. Other Details – *please provide any other patient information e.g. disabilities, special requirements or preferred date/time.*

4. Referring Clinician Details

Clinician name:		**Consultation date:**	
GMC / prof registration no:		**Clinician speciality:**	
Practice / clinic name:		**Practice tel:**	
Referring clinician signature:		**Date:**	