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REQUEST FORM: DIAGNOSTIC SERVICES & EXAMINATIONS

Please complete all sections and return a signed copy by post, fax or email.

Patient Details

Title: Mr /Mrs /Miss /Ms /Other:

Name ______________________________________ DOB _______________ Male/Female

Address ____
____

Tel __________________ Mobile ______________ Email _________________________

Referral Information (*Please circle service or examination requested)*

- Pathology (specify): ▪ HAEMATOLOGY ▪ LIPID PROFILE ▪ BIOCHEMISTRY (INC. U&Es, LFT, CK) ▪ FT4/TSH
  ▪ OTHER TESTS- SPECIFY: ____
  ____
  ____
- Ultrasound (specify): ▪ CAROTID ▪ THYROID ▪ PELVIC ▪ ABDOMINAL ▪ RENAL
  ▪ LOWER LIMB DOPPLER- VENOUS: RIGHT LEG/ LEFT LEG/ BOTH LEGS (please circle)
  ▪ LOWER LIMB DOPPLER - ARTERIAL: RIGHT LEG/ LEFT LEG/ BOTH LEGS (please circle)
- 24 hour blood pressure monitor • 24 hour holter monitor • Overnight pulse oximetry • Echocardiogram
- Resting ECG • Exercise ECG • Body Composition • Continuous Glucose Monitoring • CPX
- All Endocrine dynamic tests, including: ▪ Oral Glucose Tolerance Test ▪ Insulin Stress Test ▪ Other: ___________

** For all ophthalmic tests and for bone densitometry referrals, please see separate forms on the website.

Relevant medical history

Details (including any allergies and current medication):

Referring Clinician's Details

Consultant name: ____

Signature **(required):** ____________________________ Date: ____________

GMC Number: ____

Address: ____
____

Tel: _______________ Fax: _________________ Email: ______________________________

Results sent by post unless otherwise requested.