Cobalt Imaging Centre Referral Form

Cone Beam CT

T: 01242 535910 F: 01242 535919 E: bookings@cobalthealth.co.uk

Patient Name:

Date of Birth: **Sex: M / F**

Home phone number: ____________________
Mobile phone number: ____________________
Email address: ____________________

Insured / Self funding / NHS Invoiced
Insurance Company: ____________________
Authorisation Number: ____________________

Address:
____
____
____
____
____________________ **Postcode:** ____________________

NHS Number:

Area to be examined:

Type: Cone Beam CT

Relevant clinical summary:

Weight kg

Pregnant Y / N | Date of last menstrual cycle ____________________

Previous relevant imaging, including type, location and date:

Referrer Details

Referrer Name:
(please print)
Specialty: (i.e. GP/Consultant)

Address:

I would like images on:
CD ☐ MyVue (online) ☐ IEP ☐

If urgent report:
Fax no / Contact / Email

Signed: **Date:**

PROTOCOL:
(for Office use only)

V1 Mar 2017

Cobalt
Diagnostic Imaging for Life

Registered Charity No: 1090790