Cobalt Imaging Centre Referral Form

Cone Beam CT

T: 01242 535910 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)

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Cobalt
Medical Charity
Diagnosis • Research • Education

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