

# Community Ultrasound Request Form



**YORKSHIRE  
HEALTH  
SOLUTIONS**  
innovation & quality

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Patient Name/Label:  Address:  Postcode:                      Date of Birth:  Patient NHS No:		Home Tel:  Mobile Tel:  Work Tel:  e-mail:
Part to be scanned:		
Clinical Details:		
Referred by:  Date:	Practice/Practice code:  Secure Practice e-mail:	

## For Imaging department use only

<i>I hereby give consent to the above examination and confirm that the examination/procedure has been explained to me.</i>	
Patient Signature:   If applicable to the best of my knowledge I am not pregnant.	Operator's Signature:
Date:	Date:
Justification: This procedure has been justified under terms of the IR(ME)R 2000 Regulations	
Signature (Radiologist or Radiographer):	

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