



QUEEN SQUARE

PRIVATE HEALTHCARE

Queen Square Imaging Centre
8-11 Queen Square
London
WC1N 3AR

020 7833 2513 📞
020 7837 8074 📠
www.qsprivatehealthcare.com 🌐

Computed Tomography (CT) Referral Form

Please complete this form with all known details and return by fax to **020 7837 8074** or by email to imaging@qsprivatehealthcare.com.

Patient Details

Title: _____ Hospital Number: _____
Surname: _____ Address: _____
Forename: _____
Date of Birth: / / Postcode: _____
Mobility: _____ Telephone: _____
Is the patient? : _____ Email: _____
Insurance Details (If applicable)
Medical Insurer Name: _____ Membership Number: _____

Examination/Procedure

Examination Requested:
Relevant Clinical Details:

CT Clinical Checklist:

eGFRResult: on: / /
Date of LMP: / /

For CT examinations that involve irradiation of any region between the diaphragm and knees, patients must be within 10 days of the 1st day of their last period.

Is the patient Diabetic? Yes No

Does the patient have any known allergies? Yes No
(please provide details)

Have any previous scans been uploaded to PACS or sent to the Imaging Centre for review?

Referral Details

Referrer Name:
Report and CD to be returned to:

Signature of Referring Clinician:

Date of Request: / /

Queen Square Imaging Centre Staff Use:

QSIC Patient Number:
Appointment:

Billing:
Radiographer Initials: