



3 Denmark Street (1+2) , Altrincham, Cheshire, WA14 2SS Tel: 0161 9295679 Fax: 0161 9416486

Referral Letter

Please complete and send by fax to 0161 941 6486

Patient Details:

Surname: _____ Forename: _____

DOB: _____ Sex: _____

Address: _____

Postcode: _____ Telephone: _____

Mobile Number: _____

Funding: NHS / Self Funded / Private Patient / Other: _____

Referrer Details:

Company / Hospital: _____

Consultants Name: _____

Telephone: _____ Fax: _____

Address: _____

Postcode: _____ Email: _____

GP's Name & Address: _____

Patient's insurance company: _____ Membership NO: _____

Insurance Authorization number: _____

Scan / Examination required:

MRI

Ultrasound

Bone Density scan

Resting /Exercise ECGI

Blood Tests _____

Other: _____

Reason for referral: _____

Referrers Name: _____

Referrer Signature: _____ Date: _____

Thank you for your Referral