

**Patient Request Form**

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| Section 1**YOUR DETAILS** |
| Family Name |  |
| First Name |  |
| Date of Birth |  |
| NHS number |  |
| Hospital number |  |
| AddressPostcode |  |
| If applicable: |
| Previous Name |  |
| Previous AddressPostcode |  |
| Section 2**EXAMINATION DETAILS** |
| Examinations you are requesting (and dates if known): |  |
| Section 3**AUTHORISATION** |
| I AGREE TO MY IMAGING BEING SENT TO ELECTRONICALLY USING THE DETAILS PROVIDED BELOW: |
| Email address |  |
| Mobile Number |  |
| Name (printed) |  |
| Signature |  |
| Date |  |

**PLEASE RETURN COMPLETED FORMS TO** **XRAYREQUEST@UHS.NHS.UK**

This form will be stored by our team for 12 months. After 12 months we will delete any request forms we have received, and any new requests will need to be made with an updated request form.

If you have any queries or concerns about any of the above, please email us at xrayrequest@uhs.nhs.uk, or call the office on 02381 208196.