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| **Queen Mary’s Hospital****Radiology Department****Roehampton Lane****SW15 5PN** |



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| **Patient details**  | Male / Female |  | **GP details** |
| Surname:  |  |  | GP name:  |  |
| First name:  |  |  | Surgery address:  |  |
| DOB:  |  / / |  |
| Address: |  |  |
| Phone number: |  |  | Surgery contact details: |  |

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| **CT head referral form for adults (over 18) with chronic headache (≥15 days / month for ≥ 3 months).****CT head scanning at Queen Mary’s Hospital is a Mon-Fri service from 0900-1600 only.**Please note:* It is not appropriate to use this form for patients who have developed headache with red or amber flags (please use **Wandsworth and Merton: Primary Care Adult Headache Referral and Management Guidelines**)
* This form can be used to refer patients with new headache with recent head trauma within the last 3 months (please input clinical details in the box below)
* For other referrals, please indicate clearly in the box below the reason for referral and clinical details
* Referrals without adequate clinical information will be rejected
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| **Reason for referral and clinical details:** |
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| Possibility of pregnancy: | YES or NO |  | GP signature: |  |
| Last menstrual period: |  |  |
| Patient signature: |  |  |
| Date:  |  |