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



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

|  |
| --- |
| **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 |

|  |
| --- |
| **Reason for referral and clinical details:** |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Possibility of pregnancy: | YES or NO |  | GP signature: |  |
| Last menstrual period: |  |  |
| Patient signature: |  |  |
| Date: |  |