abc

# VASCULAR UNIT (Ext 4010 or 4210)

# email: shc-tr.salisbury-rapidreferralcentre@nhs.net

# **INVESTIGATION REQUEST**

Patient Details

(Place label here)

|  |  |  |  |
| --- | --- | --- | --- |
| **Requested by:****Designated Professional**(Name & title) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Contact no/bleep** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Referral from:****Consultant name**

|  |
| --- |
| **Reasons for Referral/Clinical details** *(continue overleaf if necessary)* |
| * *?AAA*
* *Box 2*
* *Box 3*
* *Box 4*
* *Other*

*Signature ……………………………………* |

 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Request Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*For office use only (book appointment in the following clinic):-*

|  |  |
| --- | --- |
| * Tick box 1
 | * Tick box 2
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